Exploring the Perceptions of Cultural Competence among Personal Support Workers in an Ontario Long-Term Care Home: A Case Study

Aysha Tayab, BA Honours Social Sciences

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Supervisor: Miya Narushima, PhD

Faculty of Applied Health Sciences
Brock University
St. Catharines, Ontario

Abstract

Personal Support Workers (PSWs) spend a large amount of time with long-term care (LTC) home residents providing assistance with their activities of daily living. The s limited research on their perceptions of cultural competence presents the need to bridge this knowledge gap. The researcher conducted a qualitative case study at a LTC home in Ontario. Data were collected by conducting a policy document analysis, a key informant interview with the Director of Care (DOC), and two focus groups with PSWs. The five major overarching themes were: The Culture of the LTC Home, Provision of a Supportive Environment, Collaborative Team Approach to Care, Building a Relationship with the Residents, and Maintenance of Staff Morale. The findings illuminated the broad nature of culture, connections to person centered care, and the factors that facilitate or hinder PSWs' culturally competent care. The ambiguous perception of cultural competence among PSWs suggests further research and education on cultural competence in LTC home settings.

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List of Abbreviations

AGE: Advanced Gerontological Education

CBOC: Conference Board of Canada

CHA: Canadian Healthcare Association

CIHI: Canadian Institute for Health Information

LTC: Long-Term Care

MOH: Ministry of Health

MCSS: Ministry of Community and Social Services

MOHLTC: Ministry of Health and Long Term Care

PSW: Personal Support Worker

RAI MDS: Resident Information Minimum Data Set

RNAO: Registered Nurses Association of Ontario

CHAPTER ONE: INTRODUCTION

The main purpose of this study was to explore the perceptions and practices of cultural competence among personal support workers (PSWs) in an Ontario long-term care (LTC) home. This study aims to answer the following research questions: 1) How do PSWs and Director of Care (DOC) define cultural competence in their everyday practice and work environment? 2) What are the current conditions of culturally competent care in an Ontario LTC home? 3) Are there any potential strategies for enhancing culturally competent practices in an Ontario LTC home? If so, what are they?

In order to answer the research questions, the researcher investigated a selected LTC home as a case example. Based on the findings from the study, the researcher considered the implications on how cultural competence can improve the quality of LTC delivery within the context of the selected case. It is hoped that this study serves as a resource for administrators and staff working in Ontario LTC homes, older adults and their family members, PSW training curriculum, and the Ministry of Health and Long Term Care (MOHLTC).

Problem Statement

Canada is becoming more diverse as a result of two major demographic trends: immigration and population aging. Canada is a "cultural mosaic" that welcomes immigrants from various countries. Between 1901 and 1911, 1.5 million people arrived in Canada; immigration contributed to 44% of Canada's total population increase (Novak & Campbell, 2006). After World War I, there was a large number of Europeans

immigrating to Canada (Boyd & Vickers, 2000). More recently, the 2006 Census has found that 75% of the immigrants coming into Canada were "visible minorities" (Statistics Canada, 2008). The "visible minority" population, who are from non-European countries, such as India, Pakistan, Bangladesh, Sri Lanka, Lebanon, Spain, and the Philippines, has grown dramatically in the past two decades. The 2006 Census has also reported more than 200 ethnic origins among the Canadian population. As of 2001, there have been approximately 240,000 newcomers arriving into Canada each year. The growing aging population also presents new challenges to Canadian society. The youngest members of the Baby Boom generation will turn 65 by 2031, while the oldest will turn 85 by that same time (Novak & Campbell, 2010). Since older people tend to be more frequent healthcare users (Clark & Dellasaga, 1998), healthcare providers will be providing care and services for older people more often in the future. The changing demographic in Canada has created new challenges for healthcare organizations, families, and communities that serve older people (Conference Board of Canada [CBOC], 2011; Novak & Campbell, 2006).

The demographic trends of immigration and population aging elicit a greater demand for the integration of culturally competent approaches to Canadian LTC practice. The nature of work among PSWs places a need to integrate cultural competence into their everyday practice (Parker & Geron, 2007). According to the Ministry of Training, Colleges, and Universities (2004), PSWs are required to be culturally sensitive when performing their professional duties.

PSWs are unregulated healthcare workers who provide direct care for residents by assisting with their activities of daily living on a day to day basis. There are 57,000 PSWs

working in Ontario LTC homes, most of whom are women (Lilly, 2008). PSWs are responsible for the following: personal hygiene care, transferring or positioning residents into chairs or beds, dressing and undressing, assistance with eating, assistance with toileting, and escorting the residents to appointments (Kontos, Miller, & Mitchell, 2010; MOHLTC, 2011).

A common trend among PSWs is that a large number of them are from ethnically diverse cultural backgrounds (Lilly, 2008; Parker & Geron, 2007; Stone, 2005). Given this characteristic of PSWs, culturally competent care can enable PSWs to deliver care that accommodates to the diverse needs of the residents. While it may be possible that these culturally diverse PSWs have naturally developed their understanding and tolerance to other cultural values and customs through their own adjustment to Canada, it is also possible that their limited knowledge and skills about Canadian mainstream culture and other cultures would impede their care practice from fully accommodating the needs of older adults and their family members from diverse backgrounds. Given that their work role demands frequent and direct contact with the residents on a daily basis, the training and delivery of cultural competent care would be necessarily for long-term care facilities. Unfortunately, however, there is a scarcity of evidence that culturally competent care and training is practiced among PSWs.

"Cultural competence" is defined by the implementation of behaviours, attitudes, and policies that enable staff and an organization to work effectively in cross cultural situations (Campinha-Bacote, 1999). Existing studies on cultural competence suggested that culturally sensitive and competent healthcare providers can serve as a mediator between the views of the provider and the patient (Taylor, 2005). Culturally competent

approaches to care can potentially improve healthcare for immigrants and for people from diverse ethno-cultural and religious backgrounds. In doing so, healthcare providers would extend their uni-cultural perspective to a multicultural perspective (Leininger, 1995). A multicultural perspective encourages healthcare providers to recognize and fulfill the individual needs of each healthcare recipient. While cultural competence has been a common topic of research in healthcare practice, there is a scarcity of research on cultural competence in LTC homes.

The findings of the researcher's undergraduate thesis titled "Perspectives of Canadian Muslim Adults on Quality of Life and LTC Homes" led her to conduct the present research study. The participants of the study expressed their negative feelings of LTC homes due to their perceptions that LTC homes do not provide culturally competent approaches, resources, and services that would meet the needs and preferences of Muslim older adults. Culturally competent approaches in care delivery have been indicated as an implication toward attracting culturally diverse older adults to LTC homes.

CHAPTER TWO: LITERATURE REVIEW

Introduction

The following chapter will present a review of the literature, highlighting key studies on the current healthcare services, LTC services for older adults, LTC homes in the Canada Health Act, and the changes in the nature of LTC delivery that led to the development of person centered care. Then, the researcher will introduce related literature on the concepts of culture and cultural competence, Suh's model (2004) of cultural competence (the conceptual framework for this study), cultural competence in LTC homes, the need for cultural competence among PSWs, and the limited research on PSWs' perceptions of cultural competence. While presenting the findings of the literature that is relevant to this study's topic, the researcher will identify the gaps in knowledge and present her research questions.

CANADA'S HEALTHCARE SYSTEM

Health and Healthcare Services in Canada

The concept of health has been widely recognized as more than the absence of disease. According to the World Health Organization (WHO, 1948), health is defined as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmary" (p.1). Canada's healthcare system accounts for this broad definition of health by ensuring that Canadians have access to a broad range of primary and secondary health services.

The goals and intentions of primary healthcare services are: a) to prevent and treat common diseases and injuries, and b) to provide basic emergency services and referrals

with other levels of care, primary mental healthcare, palliative and end-of-life care, health promotion, healthy child development, primary maternity care, and rehabilitation services (Health Canada, 2005). Although primary healthcare is the foundation of the healthcare system and generally represents the first point of contact individuals have with the healthcare system, Canada's healthcare system goes beyond this. Secondary healthcare services are also provided for patients who have chronic conditions and require specialized care in hospitals, LTC homes, or in the community

Long Term Care for Older Adults in Ontario

In Ontario, publicly funded LTC services are provided through Community Care Access Centers (CCAC), community services, and LTC facilities (Berta, Laporte, & Valdimanis, 2005; Cloutier-Fisher & Joseph, 2000; Daly, 2007; MOHLTC, 2011). The majority of LTC services are used by older adults (Cloutier-Fisher & Joseph, 2000). There are three major residential options for older adults: LTC homes, retirement homes, and supportive housing (Berta et al., 2005; MOHLTC, 2011). The selection of the appropriate LTC facility is often dependant upon the intensity of care that an older adult may require. Figure 1. illustrates the continuum of residential services that are offered for older adults in Ontario

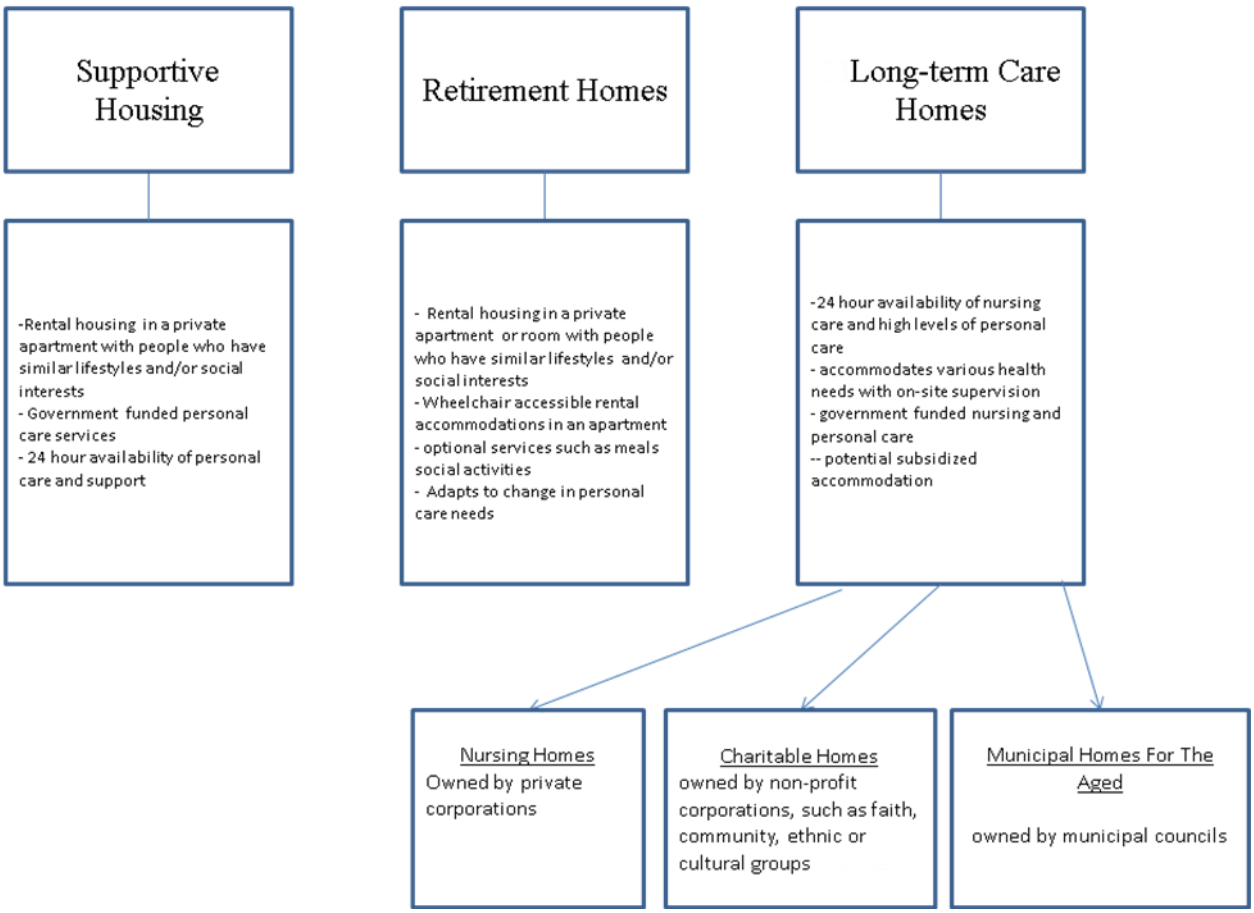

Figure 1. Residential Options for Older Adults

Figure 1.Residential Options for Older Adults. Adapted from "Seniors' Care: Overview of Care Options. "by Ministry of Health and Long Term Care (2011, November 25). Retrieved from http://www.health.gov.on.ca/english/public/program/ltc/3_overview.html

Facility based LTC in Ontario is offered in three forms: nursing homes, charitable homes, and municipal homes for the aged (Berta et al., 2005; MOHLTC, 2011). The MOHLTC sets standards for the overall operation of LTC homes in Ontario. The Residents' Bill of Rights Document (Long Term Care Act, 2007) is a government policy document which outlines the residents' rights that are expected to be maintained while living in any Ontario LTC home. While this document provides general standards, there

does not seem to be any government policy which specifically provides standards for culturally competent care in LTC homes. As stated by the Canadian Healthcare Association [CHA] (CHA, 2009), residents of a retirement home have the option to move back to their private home provided that their health condition improves. On the other end of the spectrum, the Canadian Institute of Health Information [CIHI] (CIHI, 2006) explains that older adults who require more intensive assistance with their activities of daily living may require residence in a LTC home. This research study is conducted in the context of an Ontario LTC home.

There is an increasing interest on applied research regarding the quality of care delivered in LTC homes (Cleary, 2004). Various aspects of care have been examined in research on LTC homes. The increasing recognition and integration of the social model into LTC delivery has lead researchers to investigate the efficiency of this new approach to care. This research study aims to contribute to this body of research by focusing on cultural competence in the context of an Ontario LTC home.

Long Term Care Home Residents

Although older adults prefer to age in their own homes, a number of reasons prevent this preference from being fulfilled, leading to the move to a LTC home. Firstly, as Canadians live longer, there is expected to be a greater disability rate, leading to the potential for greater demand of LTC services (CBOC, 2011; Cloutier-Fisher & Joseph, 2000). Family members may be the first resource to fulfill their care needs. However, family members may not be qualified to provide care that meets the medical needs of their elderly family members who require care (CHA, 2009).The increase in employment

rates among family members of older adults contributes to the lack of availability to provide care due to the demands of their employment (Cloutier-Fisher & Joseph, 2000). In Daly's review (2007) on the role of the social model in Ontario LTC, family members and friends are expected to fulfill the social needs of older adults requiring LTC. However, family members cannot always be available or equipped with enough knowledge to provide those services. Due to the lack of availability and training of family members, older adults may rely on community resources for support. According to the MOHLTC (2011), home and community support services are divided into four main categories: visiting health professional services, personal care and support, home making, and community support services. Unfortunately, the large number of older adults in Ontario who prefer to age at home and use of these services has overwhelmed the capacity for community support workers to meet these demands (Cloutier-Fisher & Joseph, 2000). The combination of decreased availability of informal caregivers and the limited supply of community resources may lead to the move into a LTC home. There is a possibility that the LTC home is the older adult's final place of residence. Therefore, the LTC home demands a homelike environment in order to maintain dignity and respect of older adults.

Presently, there are about 625 LTC homes in Ontario (CBOC, 2011;MOHLTC, 2011). Older adults who are currently living in LTC homes experience complex diagnoses and health conditions that require heavier care needs in comparison to the last 10-20 years (Gnaedinger, 2003). In addition, the increases in life expectancy lead to increases in the older adult population who experience age-related diseases (CBOC, 2011). The most common diseases or diagnoses among LTC residents are Alzheimer's

disease, non-Alzheimer's dementia, heart diseases, Parkinson's disease, cancer, hypertension, osteoporosis, chronic obstructive pulmonary disease, and arthritis (CBOC, 2011;CIHI, 2006). The Canadian population will be expected to increase drastically by the year 2031 to 560,000 - 740,000 (CHA, 2009). According to CBOC (2011), 238,000 older adults ranging from the ages of 71 to 89 will be in need of LTC by the year 2038. Although these estimates are relative to Canada's overall population, and not Ontario alone, these numbers are sufficient to expect a large influx of older adults who require residence into one of the many LTC homes in Ontario. Given the increasing need for LTC services, there is expected to be a greater need for PSWs (MOHLTC, 2008).

Easton's (1999) review of geriatric nursing rehabilitation practice has included the finding that culturally and ethnically diverse older adults are the fastest growing population among the older adult population. There is an increasing demand and utilization of LTC services among older adults from diverse ethnic and cultural backgrounds (Parker & Geron, 2007). According to the MOHLTC (2011), LTC homes are defined as:

> A home-like setting where a resident's physical and care needs are met, and where his or her psychological, social, cultural and spiritual needs are met as well. The government's guiding principle with respect to LTC in the province states that all homes must meet the needs of its residents (Seniors' Care Maintaining Standards in LTC Homes, para. 2).

Although the psychological, social, cultural, and spiritual aspects of the residents' needs are acknowledged in the MOHLTC's definition (2011), there lacks the evidence on whether these needs have been sufficiently met in Ontario LTC home research. Therefore, it is necessary to examine the current state of Ontario LTC practice in order to determine the degree of consistency between policy and practice.

Long Term Care Homes in the Canada Health Act

To ensure that all Canadians have access to "medically necessary services", the Canada Health Act is in place. The Canada Health Act upholds 5 principles of healthcare delivery: public administration, comprehensiveness, universality, portability, and accessibility (Library of Parliament, 2005). Public administration enables each provincial healthcare insurance plan to be administered on a non-profit basis. Comprehensiveness deems that all services are "medically necessary." However, the eligibility criterion of "medically necessary" services varies by province. In Ontario, physician care and acute care services are publically funded as a medically necessary service (MOHLTC, 2011). According to the principle of universality, all Canadian residents are granted access to public healthcare insurance and insured services on equitable terms (Library of Parliament, 2005). Portability allows Canadian citizens to be provided with healthcare insurance coverage while they are outside of their home province or Canada. Lastly, Canadians who are insured under the healthcare system are granted equal access to the healthcare system. Personal factors of age, income, or health status do not prevent Canadians from being granted this accessibility.

Inherent in the principles of the Canada Health Act (Library of Parliament, 2005) is the understanding that all Canadians, regardless of socio-demographic characteristics such as gender, age, socio economic status, religious, ethnic or cultural background, and sexual orientation are ensured unconditional access to medically necessary healthcare offered in the Canadian healthcare system. In reality, however, there appear to be inequities of health. For example, the differences in ethnic and cultural backgrounds pose challenges in the accessibility and delivery of healthcare and LTC (Newbold, 2009).

More specifically, immigrants faced challenges with accessing the healthcare system upon their arrival to Canada. Newbold's (2009) research on healthcare utilization and access among immigrants states that immigrants in Ontario usually wait 3 months after arrival before they have access to the healthcare system. Another unfortunate reality is that LTC services are not classified as "medically necessary" under the Canada Health Act because governments do not feel obligated to provide a standard range of services (CHA, 2009). As a result, there is a clear divide in funding for the services that are provided at a LTC home. In Berta et al.'s (2005) review on the characteristics of Ontario LTC homes, the researchers state that the profit status of a LTC home can influence the quality of care that is delivered as mandated by the mission, organizational priorities, and behaviour of staff. Each LTC home has its own set of unique characteristics that can be attributed to the ethnic, cultural, and religious distribution of the staff and residents. As a result, different needs may be present. Therefore, standardized services may not entirely meet the various cultural, religious and social needs that the residents require.

The CHA (2009), an advocate for health policy solutions that aim to meet the various healthcare needs of Canadians, has written a policy brief to raise awareness on the importance of LTC services. While describing the current condition of LTC in Canada, the problematic issues surrounding the funding of these services have been persistently highlighted throughout the document. Based on the ideas presented in this policy brief, residence in a LTC home should not be a last resort option, but a choice for older adults to age with dignity. Akin to the MOHLTC (2011), the CHA (2009) also acknowledged the importance of creating a homelike environment for LTC home residents.

In order to provide a homelike environment for residents of Ontario LTC homes, changes have been made to the nature of care and LTC home environment as a means to integrate social aspects of care into medical aspects of care. In 1999, the Ministry of Health became the Ministry of Health and LTC (MOHLTC, 2011).

The CHA (2009) believes that facility based LTC services should be a fully insured service, regardless of this divide between the social and medical nature of care delivery. The integration of social model of care in LTC delivery highlights the importance of personal and social care aspects in ensuring a resident's health and well being. Based on these changes in the nature of care, a new movement that addresses person centered care has been evolving since 1997 (Rahman & Schnelle, 2008). The next section will describe this movement into further detail.

Changes in the Nature of Long Term Care Toward Person Centered Care

LTC homes have been recognized as operating similar to hospital settings (CHA, 2009; Robinson & Gallagher, 2008). The task-oriented focus of care and the hierarchy among LTC home staff are the main factors that contribute to this nature of care. Kitwood (1997), the founder of the concept of person centered care, recognized that LTC home residents have five major needs that go beyond the medical aspects of care. All five of these needs fulfill the residents' needs to feel loved in their home environment. These needs are: attachment, comfort, inclusion, identity, and occupation. Kitwood (1997) strongly felt that there was a need to change the manner in which dementia care was delivered so that residents could have these major needed fulfilled. In addition, Gibson and Barsade's (2003) review on "culture change" in LTC homes problems commonly found in LTC homes that require these changes were: high staff

turnover and absenteeism, low morale, difficulty in recruiting professionals, and residents' family members expressing their dissatisfaction with the quality of care. The recognition of the institutionalized environment in a LTC home led to efforts that encourage an organizational "culture change" (Robinson & Gallagher, 2008).

The changes in care delivery are related to creating a homelike environment for LTC residents in order to meet their unique needs. In particular, "person centered care" encourages an emphasis and integration of the social model in LTC delivery, rather than solely focusing on the medical model of care (Gnaedinger, 2003; Jones, 2011; Kontos et al., 2010). In contrast to focusing on the illness or disease before the resident, the focus is placed on each resident's individual experience with an illness or disease (Edvardsson & Innes, 2010). Additional services, such as physical, speech language, and occupational therapies, and psychiatric care are offered as a part of the residents' care plans (Robinson & Gallagher, 2008). The use of assessments to evaluate each resident's individual physical and social needs was also incorporated into the practice of person centered care. This procedure facilitates the LTC staff's understanding of the resident from a holistic perspective. Through the process, the assessments of a resident's individual characteristics and needs aide LTC staff to create a resident's typical daily schedule (Gnaedinger, 2003). The move to a LTC home requires a considerable adjustment for a resident. In understanding the resident's life prior to moving into the LTC home and creating a schedule that best matches his or her lifestyle, the LTC staff may develop a greater appreciation of the resident's life and individuality. In effect, the amount of agitation that residents may experience while living at the LTC home may also be reduced.

A number of researchers provided examples of the various models that promote person centered care (Barry, Brannon, & Mor., 2005; CHA, 2009; Gnaedinger, 2003; Jones, 2011; Kitwood, 1997; Rahman & Schnelle, 2008; Robinson & Gallagher, 2008; Stolee et al., 2005). A benefit that is common among models of person centered care is the symbiotic relationship between the care provider and the resident. Person centered care further encourages LTC staff to continue putting the residents' needs first because the job becomes more rewarding (Robinson & Gallagher, 2008; Jones, 2011). Another characteristic of person centered care is the sense of empowerment that staff and residents develop (Barry et al., 2005; Kontos et al., 2010; Nayak, 2007). However, the body of literature that present these models have not explicitly stated nor recognized cultural competence as a factor that promotes person centered care. It may be possible that cultural competence, a relatively new concept in LTC research (Parker &Geron, 2007), has not been introduced to LTC delivery.

Since the nature of LTC has been delivered with a focus on the medical model for a long period of time, the full implementation of person centered care has been noted as a challenging feat (Gnaedinger, 2003). It takes time and effort for LTC homes make "cultural changes" and to fully incorporate person centered care into everyday practice (CHA, 2009; CBOC, 2011;Crandall, White, and Talerico, 2007; Jones, 2011;Nayak, 2007; Rahman& Schnelle, 2008). Within the Ontario LTC home context, the progress of this cultural change and the PSWs perceptions in relation to these changes to the nature of care remains in question.

CULTURAL COMPETENCE

Defining Culture

An understanding of cultural competence first requires an understanding of the concept of culture itself (Shen, 2004). There are a variety of definitions of the concept of culture. A number of researchers and authors defined culture through the lens of their own academic discipline. Mitchell (1995, p. 103), a geographer, stated that culture "differentiates the world and provides a concept for understanding that differentiation." Easton (1999), a geriatric nursing scholar, stated that culture is the attitudes, thoughts, values, and beliefs that influence and dictate behavior. The Registered Nurses Association of Ontario [RNAO] (RNAO, 2007) defined culture as the "learned and transmitted beliefs, as well as information and values that shape attitudes and generate meanings among members of a social group" (p.28). Both Easton (1999) and the RNAO (2007) developed their definitions through the same disciplinary lens in nursing. Gibson and Barsade (2003), who provided a review of the culture in a LTC home, referred to the culture of an organization as "the value-laden glue that can bind people to each other and to the organization" (p.14). Although the majority of the aforementioned definitions are mutually exclusive from a definition of cultural competence, these definitions highlight that the concept of culture is broad and relative to the academic discipline of the individual who defines culture. Culture should be examined within a broad scope that is not limited to geographic origin, age, gender, ethno-cultural identification, language, or sexual orientation (RNAO, 2007).

A great deal of overlap occurs among terminologies that are associated with culture (RNAO, 2007). These terminologies include "race", "ethnicity", "immigrant",

and “visible minorities.” However, James (1996) and Boyd and Vickers (2000) clarified the distinctions among these terminologies. James (1996) a sociologist, stated that the term “race” is often associated with “ethnicity”, “immigrant”, and “culture”, leading to an interchangeable use of terminologies. Assumptions of one’s culture are often based on physical characteristics such as skin colour. According to James (1999), “colour becomes a defining factor of individuals and whole groups of people. It denies some racial groups and individuals the full expression of who they are” (p.25). Although, ethnicity has been commonly confounded with race, Maville and Huerta (2002) differentiated the two terms by referring to “ethnicity” as “a large group of people classified according to common national, tribal, linguistic, or cultural origin or background *and* who feel a sense of shared identity” (p.99). In addition, Boyd and Vickers (2000) clarified the differences between the terms “immigrant” and “visible minorities.” “Immigrants” are defined as people who have been granted permission to reside in Canada. Canada’s Employment Equity Act describes “visible minorities” as people who are not Caucasian in race or non-white in colour. Based on the definitions of these terminologies, it is evident that many factors can influence the way culture is defined at an individual level. In order to provide care that is truly culturally competent, these factors need to be considered.

Based on the overlap between terminologies associated with culture, LTC staff may misunderstand a resident’s race to be the same as his or her ethnicity and culture. When a LTC staff member is caring for a resident who is a visible minority or belongs to a certain ethno-cultural group, it is erroneous to assume that their racial background will dictate their behavior as individuals. According to the RNAO (2007), people who belong to the same racial group do not necessarily follow the same practices and beliefs that their

homeland's culture or religion demands. In addition, people who share a common language do not necessarily share the same lifestyle choices from their ethno-cultural background. Ultimately, culture is a personal and individual characteristic that defines one's identity.

Conceptual Development of Cultural Competence

The concept of "cultural competence" began with the work of Madeline Leininger in 1978 (Leininger, 1995) and Arthur Kleinman (Srivastava, 2007). Leininger is a nurse scholar and Kleinman is a medical anthropologist (Srivastava, 2007). Their academic and professional experiences have led them to develop theories on the nature of health and healthcare. Kleinman (1995) recognized the important role that culture plays in health status, while Leininger (1995) recognized the important role that culture plays in the healthcare delivery, specifically within the realm of nursing practice. Their contributions to medical anthropology and nursing practice have set a foundation for the development of cultural competence in healthcare practice.

Leininger (1995) and Kleinman (1995) believed that optimal health goes beyond the domains of biomedicine. Kleinman (1995) stated that there is "no essential medicine" (p.23). In other words, there is no single form of medicine that dominates all other forms. There are wide arrays of healing and medical systems that are utilized by cultural groups. Medicine and healing are relative constructs intertwined with culture. Therefore, the experience and perceptions of illness and disease vary among individuals. An awareness of these differences may encourage cultural sensitivity in providing care.

Definition of Cultural Competence

Kleinman's (1995) and Leininger's work (1995) provided a foundation for nurse educators and scholars to build upon. Cultural competence in healthcare is defined by the implementation of behaviors, attitudes, and policies that enable staff and the organization to work effectively in cross cultural situations (Campinha-Bacote, 1999). More recently, in the Canadian context, the RNAO (2007) defined cultural competence as "a sense of respect for others as well as a search for greater meaning in how to live and work together with ease and understanding" (p.28). A high demand for healthcare services among Canadians from various ethno-cultural backgrounds further encourages the need for culturally competent healthcare practice.

The diversity of cultural, ethnic, and religious groups of people residing in Canada challenges LTC staff to provide culturally competent care. It is a challenge to be knowledgeable of all cultural norms, beliefs, and practices. Taylor (2005) and Shapiro, Hollingshead, and Morrison (2005) suggested some approaches that may aid in overcoming this challenge, thereby enhancing the delivery of culturally competent care. The culture general approach is defined in Taylor's (2005) review on the challenges toward implementing cultural competence. In the culture general approach, healthcare staff learn the knowledge, skills, and approaches that can be used with any group or individual from any cultural background (Taylor, 2005). In Shapiro et al.'s (2005) study on healthcare staff's perspectives on the barriers to cultural competence, the culture generic approach is recommended to improve cross-cultural communication. The culture generic approach is similar to the culture general approach that is provided in Taylor's (2005) review. This approach is hoped to encourage healthcare providers to decrease the

risk of placing stereotypes on the care recipient (Shapiro et al., 2005). These approaches contribute toward the provision of culturally competent care through the recognition of each patient's unique characteristics.

Although the efforts to develop the concept of "cultural competence" contributes toward improving current healthcare practice in North America, the concept is still not specific enough, nor entirely applicable, to the Ontario LTC home context. A LTC home is not only a healthcare facility, it is also a residence during an older adult's last stage of life. This differing nature of a LTC home may regularly present situations which require cultural competence of the care providers including PSWs. However, research on the PSWs' experiences with cultural competence is scarce. Therefore, further research is needed on the concept and practice of cultural competence in the context of a LTC home from the perspective of PSWs.

Suh's (2004) Model of Cultural Competence: Conceptual Framework for the Study

A number of researchers contributed toward the further development of cultural competence by creating various conceptual models. Shen (2004) produced an annotated bibliography that examined the growth in literature on cultural competence; twenty models of cultural competence were presented, most of which were developed and used for nursing education in order to improve the quality of healthcare delivery. Among these models, the researcher has selected Suh's (2004) model of cultural competence for this research study. Suh's (2004) model was developed for nurses in acute care settings to be culturally competent.

In Suh's article (2004), cultural competence is described through the lens of different academic disciplines such as nursing, medicine, psychology, education, and

social work. Based on the contents of cultural competence models that were designed for healthcare practice, she described common trends of culturally competent nursing practice and developed her own model. Also she provided hypothetical examples that illustrate how nurses can use these culturally competent approaches to care. Suh (2004) believed that the concept of cultural competence has changed over time. Historical and contextual backgrounds of specific populations are dependant upon the way the concept is defined. Figure 2. provides Suh's (2004) illustration of her cultural competence model.

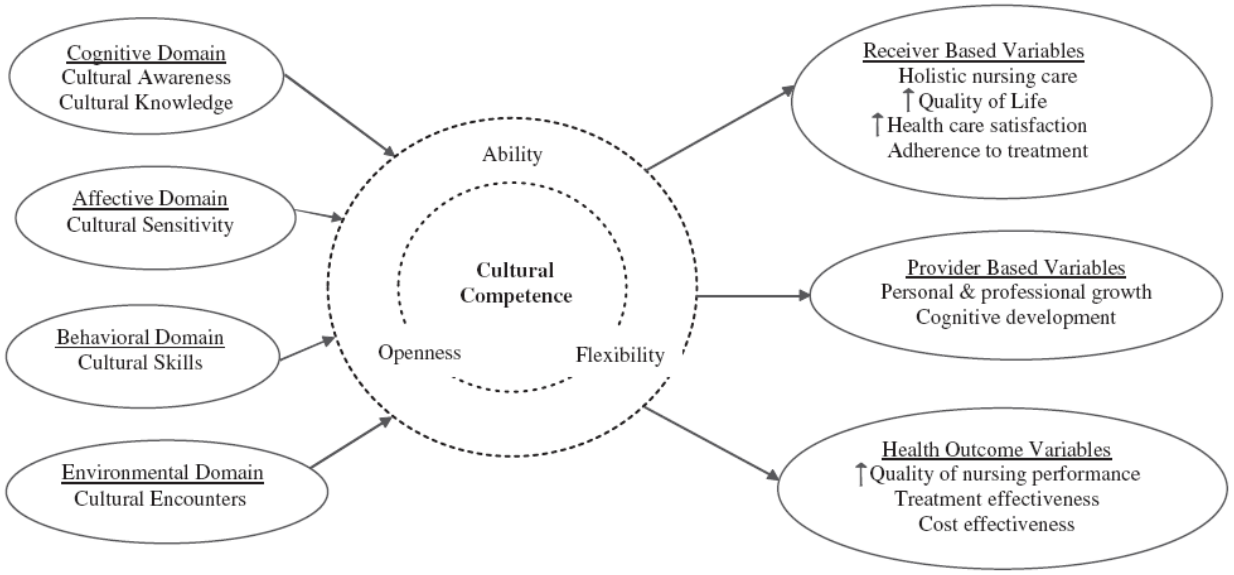

Figure 2. Cultural Competence Framework by Suh (2004).

Retrieved from "The Model of Cultural Competence Through an Evolutionary Concept Analysis." By Suh, E.E. (2004; p. 97). *Journal of Transcultural Nursing, 15*(2), 93-102.

In this model, cultural competence is established through the antecedents of cultural competence that contain four domains. These four domains are: 1) the cognitive domain, 2) the affective domain, 3) the behavioral domain and 4) the environmental domain. These domains were chosen as "events or incidents that must precede the occurrence of a concept" (Suh, 2004, p. 97) also referred to as antecedents. Within each

domain are constructs of cultural competence of “awareness”, “knowledge”, “sensitivity”, “skills”, and “encounters” that are commonly recognized in major models of cultural competence.

The domains are achieved through optimal integration of “ability”, “openness”, and “flexibility”, also described as the *attributes* required for nurses to be culturally competent. “Ability” is defined as the nurse’s capacity to provide care for ethnically diverse patients in an effective manner. Efficacy is determined by the extent to which nurses are able to resolve cultural conflicts between the healthcare provider and the patient. Utilizing these abilities helps the nurses to resolve cultural misconceptions between healthcare providers and a patient. “Openness” involves a nurse’s willingness to have an open mind in order to be culturally competent. The nurse must be open to the cultural diversity that persists among the patient population. In conjunction with such openness, nurses are required to demonstrate “flexibility” in order to adapt their practice to diverse patient groups. To demonstrate flexibility, nurses must be able to apply their professional skills with any cultural group. These three attributes are the central focus of cultural competence. The mastery of the antecedents of cultural competence in conjunction with these three attributes lead to benefits for patients, healthcare providers, and the overall healthcare organization.

As the *outcome* of enhanced cultural competence at both personal and organizational levels, patients benefit from the receipt of “holistic nursing care”, “improved quality of life”, “improved healthcare satisfaction” and “adherence to treatment” (Suh, 2004). Culturally competent healthcare providers are equipped with the skills that enable these benefits. Healthcare providers can also benefit from becoming

culturally competent by "develop [ing] personal and professional growth" and enhancing their "cognitive skills" (Suh, 2004). As a result, a higher level of awareness and knowledge of a patient's cultural background is achieved, leading the healthcare provider to consider the patient's cultural needs. Lastly, cultural competence can also provide numerous benefits to the healthcare organization in that it can improve the "quality of nursing performance, and result in "treatment and cost effectiveness" (Suh, 2004). Treatments become more effective due to improved communication and better understanding between the patient and the healthcare provider.

Overall, the enhanced cultural awareness, knowledge, sensitivity, skills and encounters are intended to aid healthcare providers to tailor their care in a manner that meet to the patient's needs while still benefiting the patient's health. The implementation of cultural competence promotes efficient understanding and communication between the healthcare provider and the patient. Both parties benefit from each other as cultural competence is continuously integrated into everyday healthcare practice. Suh's (2004) model of cultural competence contributes to the breadth of research on cultural competence. However, this model was created for nursing practice in acute care health care settings and has not been evaluated in LTC homes. The researcher will incorporate this model into the following research study in order to determine it's relevance to the LTC home context.

Ability of Long Term Care Home Staff to Provide Culturally Competent Care

In order to understand the determinants affecting the provision of culturally competent care in LTC homes, it is necessary to understand the staffing and polices that comprise a LTC home. A hierarchy is present in the staff composition of a LTC home (Kontos et al., 2010). The top of the hierarchy are the administrators or managers of the LTC home. The remaining staff members work in accordance with the direction of the administrators and policies. Residents of a LTC home receive nursing and personal care on a 24-hour basis and access to a physician, and care from other health professionals (CBOC, 2011; MOHLTC, 2010).Other departments maintain the resident's housekeeping, dietary, recreational, and leisure needs. Policies provide the expectations on the successful delivery of optimal care for the residents.

Literature findings suggest that the hierarchical nature of work among LTC home staff was found to be problematic in the delivery of care. The findings of Stolee et al.'s (2005) study indicated that differences in education levels among staff members created the hierarchical nature of care delivery. According to Parker and Geron (2007), differing education levels impacted the staff members' awareness levels on the important role that culture can play in LTC. For example, administrators' greater awareness of the importance of culture may have been based on their advanced education and training. However, another key finding in this study is that much is lost in translation as well as practice due to the fact that administrators and staff had differing ideas on the quality of care because administrators did not transfer this pertinent information to other staff

members, such as PSWs. Based on the findings from this research study, the lack of consistency in knowledge across staff departments greatly impacted the work of PSWs as well as the quality of care provided to residents. LTC home administrators influence the degree to which changes are made in a LTC home (Stolee et al., 2005). According to Gnaedinger (2003), administrators may not be focused on the needs of a specific home due to their managerial positions at other LTC homes. The impact of this type of responsibility may lead administrators to be less aware of the unique changes that are needed at one LTC home. Another problematic issue resulting from this hierarchical nature of care is attributed to the administrator's inability to respond appropriately to PSWs' complaints on receiving racially discriminatory comments from residents (Parker & Geron, 2007). The participants in the study stated that PSWs' dissatisfaction with their work conditions was elevated as a consequence of neglecting these conflicts. Within the Canadian context, Kontos et al. (2010) found that the absence of PSWs in care planning meetings created problematic circumstances for the PSWs' work conditions and their relationship with the residents as a result of hierarchical decision making.

Stolee et al. (2005) suggest that tension between departments can be eliminated through an egalitarian and lateral approach to LTC delivery. This egalitarian approach has also been implied through a culture change of the LTC home (Gibson & Barsade, 2003). The benefit of an egalitarian and lateral approach to LTC delivery is that staff members play an equal role in the decision making process (Janes, 2008; Gnaedinger, 2003; McAiney, 1997). The equal role in decision making is based on acknowledging the unique contributions that each staff department has to offer. McAiney (1997) developed a model that would help to improve the conditions of Canadian LTC homes by allowing

PSWs to feel empowered. This model was called "The Empowered Aide Model," also known as TEAM. According to McAiney (1997), PSWs can be empowered by becoming key members in decision making in a LTC home. In addition, Janes' (2008) qualitative research on PSWs in Ontario and their ability to provide person centered care sheds light on how the nature of their work role positively contributes to the decision making process. This pragmatic decision making process has been summarized by a approach called "figuring it out in the moment." Overall, the process was primarily characterized by the capacity to focus on their own individual strengths and knowledge as PSW as well as a "team sharing" approach that enables staff to work together in the decision making process(Janes, 2008; p. 20) .

Although recent research efforts have been made to examine LTC home policies for evidence of cultural competence, the mere examination of polices implies the possibility and potential for culturally competent care and does not provide contextualized evidence of the practice of culturally competent LTC delivery (Parker & Geron, 2007). In order to fill this gap in research, an exploration of the perceptions among PSWs of cultural competence in the context of a LTC home is needed. Due to the nature of care that PSWs deliver, these perceptions will provide insight on the practices and conditions that are present in Ontario LTC homes.

Cultural Clash in Long Term Care Homes

While examining the current literature on LTC homes, it appears that there are a number of challenges that both the residents and staff experienced. The related literature that describes these challenges are summarized by the researcher as the term "cultural clash."

One dimension of this cultural clash derives from LTC staff's limited knowledge and understanding of a resident's own cultural beliefs and practices. For example, Chinese older adults experienced many difficulties in adjusting to the LTC home environment. Major difficulties involved: communication barriers, dislike of Western food, differing views on medicine and optimal health, and differing beliefs and customs (Chan & Kayser-Jones, 2005). Based on this study, the LTC home staff members were not aware of the cultural norms that would accommodate to the resident's everyday comforts. As unregulated and low ranking staff in LTC homes, PSWs are not always part of the care planning team and do not have access to the residents' personal information (Kontos et al., 2010).

Although it is important to respect and preserve the diverse cultural practices and beliefs among the residents, there are some instances wherein a cultural practice is harmful to a resident's health. In Chan and Kayser-Jones' (2005) study, the LTC home staff were not aware that the Chinese residents used Traditional Chinese Medicine in conjunction with Western medicine prescriptions; the results of this practice can be harmful due to the interactions between the differing drugs. Therefore, the continuation of that practice may need to be eliminated or accommodated. As indicated in Kemp's review (1996), Muslim older adults are permitted to maintain the practice of fasting during the month of Ramadan if their fasting period during the day does not disrupt their prescribed intake of medications. Through this compromise, Muslim older adults maintain and fulfill their religious values and practice in a manner that does not impact their health condition. This dimension of the cultural clash can be minimized or eliminated through the integration of culturally competent care. Culturally competent

care allows LTC residents to feel comfortable in their new home environment because the care providers have an increased understanding and appreciation of the cultural practices and beliefs that are most meaningful to the residents.

A second dimension of the cultural clash is the staff members' limited understanding of the resident's collective experience from the past. Generational differences between the LTC staff members and residents contribute to this component of the culture clash. Most LTC providers are younger than the resident population they serve. Shared historical events can impact the ways in which an older adult ages and views the world. LTC staff may not have a full understanding of the residents' experiences. Such is the case with LTC home providers' experiences with residents who previously experienced the trauma involved in the Holocaust (Brandler, 2000; Kontos et al., 2010). In Kontos et al.'s (2010) study, PSWs gathered a better understanding behind a residents' "erratic" behavior when a memory of their experiences with the Holocaust was triggered. Knowledge of the factors that create these unpleasant circumstances will encourage LTC staff to make the residents' home more comfortable.

Lastly, a third dimension of this cultural clash is the misunderstandings between the resident and staff due to the differences in professional status and the resource constraints of a LTC home. LTC home staff members have a culture within their own profession and residents may not be able to gain a full understanding of this culture. This culture is related to the medical model of care which is characterized by a routinized schedule, placing more emphasis on the task instead of the individual; it does not allow much opportunity for interaction between the healthcare provider and the older adult resident (Crandall et al., 2007; Kontos et al., 2010; Robinson & Gallagher, 2008;

Robinson & Rosher, 2006). PSWs' view of the residents as members of their own family stimulates their desire to learn and fulfill each resident's unique needs and preferences (Kontos et al., 2010). The findings of Gnaedinger's study (2003) on PSWs who work in British Columbia LTC homes revealed PSWs frustrations and disappointments with their lack of opportunity to learn about the residents' needs; a consequence of the uneven staff to resident ratio. Residents feel helpless due to the lack of opportunity to voice his or her opinions.

Furthermore, a resident's opinion may not be valued as a result of insufficient staffing in LTC homes. Cloutier-Fisher and Joseph (2000) found that the members of administration in LTC homes are minimizing services in order to stay within a budget. In a report on staffing standards developed by the MOHLTC (2008), LTC home administrators are granted the flexibility to delegate and determine where the home's available finances will be distributed. More emphasis may be placed on allocating finances toward staff education, leadership development, and workplace improvement rather than increasing staff positions. The impact of insufficient staffing is reflected in Gnaedinger's (2003) findings that suggest short staffing pressures PSWs to complete tasks that other staff departments are responsible for. The PSWs in this study discussed that this overlap between staff departments can be problematic when they are responsible for fulfilling their own work role. The PSWs are in between catering to the physical as well as social needs of care (Lilly, 2008). Therefore, their routine becomes more rigid, leaving less opportunity and time to collaborate with other staff members and participate in the decision making process (Barry et al., 2005). There is a need to investigate whether cultural clashes occur in an Ontario LTC home and how PSWs handle these situations.

Personal Support Workers and Work Conditions

Specific characteristics of PSWs and their work conditions have been shown to be challenging. These factors can inhibit the PSWs' ability to provide person centered or culturally competent care. The following subsections will provide detail on how they may impact the capacity to provide culturally competent care.

Cultural Diversity among PSWs

Parker and Geron's (2007) findings from their research on cultural competence in LTC homes suggested that culturally diverse PSWs experience language barriers between their co-workers, the residents, and the residents' family members. Family members who participated in Parker and Geron's (2007) study expressed their difficulty in communicating with PSWs as a result of cultural differences. In addition, cultural differences affect the quality of communication between PSWs and nurses. Misunderstandings in communication commonly occurred while PSWs were taking instructions from the nurses or if PSWs were reporting problems to nurses, leading PSWs to avoid verbal interactions. Also, PSWs received racially discriminatory remarks from the residents; these remarks would be ignored when reported to other staff departments. Based on these findings from Parker and Geron's study (2007), cultural competence is not a given attribute among PSWs who come from diverse cultural and religious backgrounds. PSWs, regardless of cultural or religious background, need to receive cultural competence training in order to increase their level of understanding of the residents and minimize the impact that the language barriers, discriminatory attitudes and remarks can pose (Parker & Geron, 2007).

Staffing Procedures

Gnaedinger (2003) described three common problematic trends in hiring PSWs in British Columbia LTC homes. The first trend is related to the extensive reliance on "casual" workers. Casual workers provide services to fill the positions when full-time staff are unavailable to work. It is likely that they may not be assigned to work with the same residents on a consistent basis. As a result of this inconsistency, PSWs who are hired to work on a casual basis have limited exposure to the same residents and the environment of the LTC home and are thereby limited from providing person centered care. Permanent staffing promotes the continuity of care (MOHLTC, 2008). It remains questionable as to how the issue of continuity of care impacts PSWs' capacity to provide culturally competent care.

The frequent reliance on generic job descriptions or "benchmarks" also created problems in hiring procedures (Gnaedinger, 2003). Benchmarks are referred as the generic job descriptions that state the skills and training required for an employment position. According to Gnaedinger (2003), the benchmarks "do not adequately take into account the skills and attitudes required to work effectively with people with dementia" (p. 364).Another problematic issue in regards to hiring procedures is that LTC homes managed under a union contain hiring policies based on a potential staff member's seniority and not their suitability.

Based on the findings from Gnaedinger's (2003) study, these hiring procedures reduce the quality of care and, further compromise the resident's individual cultural needs and preferences. While this study was conducted in British Columbia, the findings may not be applicable or transferrable to Ontario LTC homes. There is a need to

investigate hiring procedures within the context of Ontario LTC homes in order to determine the degree of consistency in these procedures.

High turnover rates

In the body of literature on LTC homes, researchers have commonly found that there is a high turnover rate among PSW staff (Barry et al., 2005; Gibson & Barsade, 2003; Stone, 2004). High turnover rates create problems for the residents because of the inconsistent care provision (Gnaedinger, 2003). Residents are comfortable when they develop a trusting relationship with their care providers. In effect, the ability to provide culturally competent care can potentially be disrupted if there is a high turnover rate among PSW staff. Due to their frequent and direct contact with the residents, contact with the same PSWs is needed in order to build a relationship and learn about a residents' culture. Also, high turnover rates can be an expensive issue to manage.

The reasons for the high turnover rates are uncertain and may be dependent upon the unique qualities of each LTC home. Barry et al. (2005) found that high turnover rates may be based on the authority of the LTC home administrator as is also necessitated by the need to filter out an abundance of poorly qualified and inexperienced staff who did not receive effective training. However, Barry et al.'s study (2005) focused on improving the quality of care for physical ailments, such as pressure ulcers, and did not acknowledge the importance of cultural and social aspects of care. Another reason why PSW staff may be deemed under qualified is attributed to the low education requirements of PSWs employed in Ontario, their brief training period ranges from 12-20 weeks at a community college (Stolee et al., 2005). As a result of this lack of training, Kontos et al.

(2010) state that PSWs are not prepared to execute independent decision making. Increased standards for staffing levels and educational requirements are believed to improve the PSWs' qualifications (Stolee et al., 2005).

Limited Decision Making Power

PSWs have limited decision making power while providing care for older adults. The PSWs' exclusion from care planning is an example of their limited decision making power (Kontos et al. 2010). According to Barry et al.'s research (2005) on the effects of empowerment strategies for PSWs, the amount of decision making power among PSWs is dependant upon the environment of the LTC home. The opportunity to have greater decision making power enables the PSWs to have sense of control over their working conditions.

A collaborative team approach to care can prevent inconsistencies in care delivery (Gnaedinger, 2003; MOHLTC, 2008). The frequent and direct contact with the residents places PSWs at an advantage to inform the nursing staff and DOC of any concerns or changes that they notice in the residents (Gnaedinger, 2003; Kontos et al., 2010). The findings from previous studies suggests that a collaborative approach to care, such that cultural competence offers, would help to achieve a sense of consistency in decision making power because all staff members would be equally informed of the resident's needs (Janes, 2007; Geron & Parker, 2008). Culturally competent care would also be enhanced by this collaborative approach to care.

Research Gap on PSWs' Perceptions of Cultural Competence

According to Barry et al. (2005), the topic of PSW research is gaining momentum. Although there is still limited research on the perspectives of PSWs, Stolee et al. (2005) acknowledge that a greater recognition is being placed on the important role of PSWs in LTC delivery. Kontos et al. (2010) have found that the contents of the Resident Assessment Information Minimum Data Set (RAI MDS), an assessment tool that is widely used in Canadian LTC homes, lack a focus on the social aspects of each resident and instead place a higher focus on the residents' health condition. Therefore, care plans are not individualized. The PSW participants from this study also discuss that previous assessments contained a detailed history of each resident; they expressed disappointment with the elimination of this procedure. Kontos et al. (2010) concluded that the use of RAI MDS does not yield enough of the residents' individualized details in their care plans due to the lack of assessment on personal needs beyond physical and health conditions. However, findings of the study also suggested that PSWs offer a body of knowledge, insights, and connections with the residents that cannot be inserted into a standardized assessment tool. Nevertheless, the PSWs are not included in the care planning process teams in many LTC homes. Kontos et al.'s study (2010) made a significant contribution toward understanding the ways in which culturally competent care can be integrated into LTC home through PSWs' everyday practice. Based on the nature of their work, PSWs have more opportunities to learn information about older adult residents that other staff departments may not be aware of (Kontos et al., 2010).

Parker and Geron's research (2007) on an intervention to enhance cultural competence among LTC home staff at 10 selected LTC homes, has created a first step

toward filling the knowledge gap on cultural competence in LTC homes. The major findings of this study suggest that cultural competence has not been successfully implemented in these homes based on a number of concerns that were commonly found in the LTC homes. Such concerns are as follows: uneven staff awareness of cultural differences among residents, challenges in both verbal and non verbal communication, discriminatory comments and actions toward staff, and inadequate responses toward resolving such comments and actions. However, this study was conducted in the United States. While findings of the study contribute pertinent information on the state of cultural competence in LTC homes, it is necessary to explore this issue within the context of an Ontario LTC home due to the differences in policies on LTC. In contrast to LTC homes in the United States, as well as other provinces in Canada, the regulations for LTC delivery may affect the capacity to provide culturally competent care.

Both Kontos et al.'s (2010) and Parker and Geron's (2007) studies used qualitative methods to explore the PSWs' roles and the conditions of cultural competence in LTC home settings. Since these topics are still understudied, and they are also specific to the context of the research study, the use of a qualitative approach to explore these topics seems to be sensible. As well, these aforementioned qualitative studies provided opportunities to have PSWs voices heard.

Conclusion

After reviewing the literature, the researcher notes that the changing Canadian demography requires more integration of cultural competence into the care that is provided in LTC homes. It appears that there are still numerous barriers involved in delivering culturally competent care in the LTC context due to the cultural clash between

residents and staff and the work conditions of the PSWs. The scarcity of studies on cultural competence in the context of Ontario LTC homes leaves many unanswered questions about the current conditions of culturally competent practice, organizational needs for and perceptions of cultural competence, and related personal and environmental barriers to culturally competent care facing its staff and administrators. Therefore, through a qualitative case study approach, this study aimed to answer the following questions:

1. How do the PSWs and DOC define cultural competence in their everyday practice and work environment?
    a. What are the experiences of PSWs and the DOC in relation to cultural competence?
    b. How do PSWs and the DOC perceive the meanings of culturally competent care?
2. What are the current conditions of culturally competent care in an Ontario LTC home?
    a. Are there any policies and resources which promote culturally competent care in an Ontario LTC home? If so, what are they?
    b. What are the challenges and barriers to promote culturally competent care in an Ontario LTC home?
3. Are there any potential strategies for enhancing culturally competent practice in an Ontario LTC home? If so, what are they?

The next chapter will describe the methods that were used to collect data and led the researcher to answer the study's research questions.

CHAPTER THREE: METHODS

Introduction

The purpose of this study was to understand PSWs' experiences and perceptions of culturally competent care, as well as their perceived needs and the factors that influence their practice of cultural competence in the context of an Ontario LTC home. These issues were explored through the case study approach. The following chapter presents the research design, methodological approach, methods of data collection, methods to ensure validity of results, the role of the researcher's reflexivity, and the study's ethical issues.

Research Design

The researcher's theoretical and epistemological assumptions are the foundation that supports the decision to conduct a qualitative study. According to Creswell (2007), the epistemological standpoint poses the following question "what is the relationship between the researcher and that being researched?"(p.17).The researcher was interested in learning about the nature of knowledge and how it is constructed by a group of PSWs working in an Ontario LTC home. An epistemological standpoint values the collaborative nature of knowledge development. In order to incorporate this aspect of qualitative research into her study, the researcher aimed "to get as close as possible to the participants being studied" (Creswell, 2007, p.18) by collecting data through face-to-face communication. The researcher developed an understanding of their experiences and opinions, which were then incorporated into the knowledge creation process.

In relation to her theoretical assumptions, the researcher viewed the social world through the lens of "social constructivism." The goal of social constructivism is to seek

understandings of the subjective meanings that are given to certain human experiences (Creswell, 2007). This theoretical stance overlaps with the notion of "multiple realities." Merriam (2009) notes that a qualitative researcher views that "there is no single, observable reality of human experiences" (p.8). A qualitative study is a useful methodological approach designed to understand the complexity and multiple dimensions of reality that individuals experience and construct in their unique contexts. In this study, the researcher viewed "cultural competence" as a concept that is socially constructed in a context that is specific to the unique personal and professional lives of PSWs. Therefore, the researcher examined how the organizational policies, the work environment, and personal backgrounds of PSWs influenced their perceptions and practice of cultural competence in a LTC home.

According to Patton (2002),the characteristics of qualitative research studies are: purposeful sampling, personal contact and insight, context sensitivity, voice perspective and reflexivity, empathic neutrality, dynamic systems, unique case orientation, and creative synthesis. Creswell (2007) elaborated that qualitative studies incorporate an emergent design, inductive data analysis, multiple sources of data, the researcher as a key instrument, an emphasis on participants' meanings, a theoretical lens, interpretive inquiry, and a holistic account. The next sections will provide further details on how these characteristics were incorporated into this research study.

Methodological Approach

Each methodological approach comes with its own set of guidelines. In qualitative research, it is important to carefully select an approach that will best answer the research questions and fulfill the goals of the study (Creswell, 2007; Merriam, 2009). The selected

methodological approach for this study was the case study approach. There are a number of approaches and definitions toward conducting a case study, (Creswell, 2007;Stake, 2005; Yin, 2008) however, the researcher chose Merriam's (2009) framework for a case study because of its detailed step by step instructions that are clear and simple to follow.

According to Merriam (2009), a case study is defined as "an in-depth description and analysis of a bounded system" (p.40). In this research study, the bounded system of a selected Ontario LTC home was described and analyzed. Figure 3. presents an illustration of how this concept of a bounded system was translated to the LTC home setting.

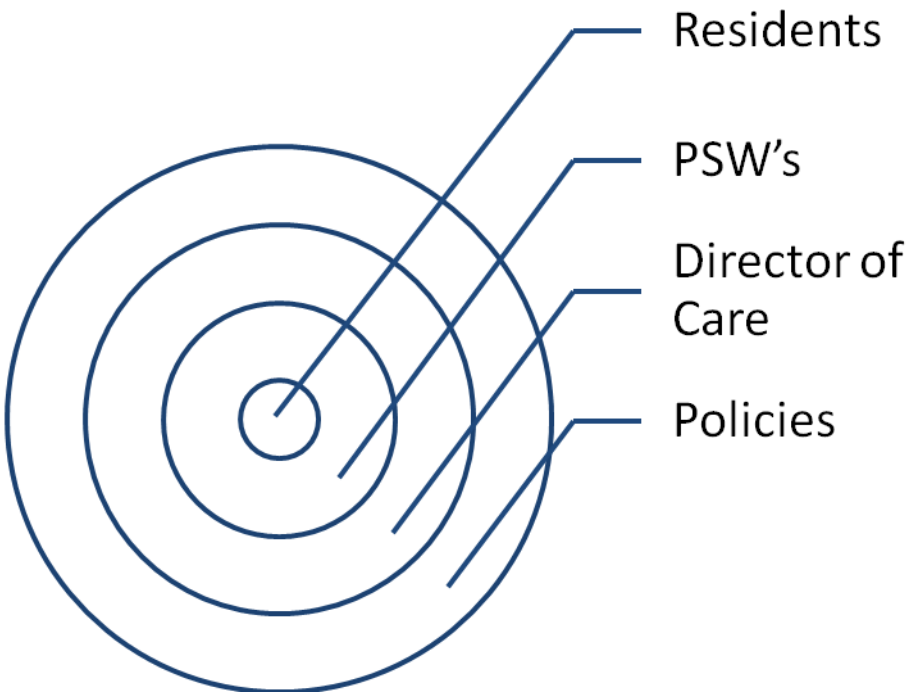

Figure 3. Bounded Nature of a LTC Home

In a LTC home, the residents are at the heart of the organization, the sole purpose for the LTC organization to run. Among all staff departments, PSWs provide the most direct

care to the residents (CBOC, 2011; Janes, 2008; Kontos et al., 2010). The DOC, meanwhile, provides guidance and supervision to the staff in ensuring that care is properly delivered as mandated by the policies of the LTC home. Furthermore, a LTC home has an established space and schedule in which care-related duties are to be fulfilled. Staff members are required to complete specific tasks under a schedule that is intended for a successful operation of the LTC home.

The researcher used multiple data sources to uncover the bounded nature of the selected home. The collection and analysis of the multiple data sources produced a holistic perspective of the case. The main focus of case study was to develop an in-depth context-based understanding and description of the case (Creswell, 2007).The selection of the case study approach led the researcher to a particular sampling strategy. This strategy will be discussed in the next section.

Sampling Strategy

A purposeful sampling strategy was used for this study. Purposeful sampling "is based on the assumption that the investigator wants to discover, understand, and gain insight and therefore must select a sample from which the most can be learned" (Merriam, 2009, p. 77). In other words, the sample for a qualitative research study must be "information rich" in order to answer the research questions. The researcher was mindful of the "information rich" characteristics of her participants from utilizing the purposeful sampling technique. In a case study, there are two levels of purposeful sampling; the selection of the case, and the selection of the participants (Merriam, 2009).

The following subsections will provide further detail about how each sampling level was utilized for this study.

Case Selection

This research study was designed as a single site case study. An Ontario LTC home was chosen as the case. The researcher utilized the criterion-based method for selecting the case (Merriam, 2009). The researcher aimed to select an "information-rich" case. The selection criterion included: a relatively large LTC home in Ontario that comprised ethno-culturally diverse staff and residents. This criterion was necessary to fulfill the study's focus on cultural competence.

The researcher contacted various LTC homes in the Niagara region. However, many LTC homes in the region do not have much ethno-cultural diversity among the staff and residents. Although staff from a retirement home in the Niagara region, where the researcher was previously employed, expressed their interest in the study, the nature of the "retirement home" did not match the case criterion.

The next option was to search for a case in a larger city such as the Hamilton region. The researcher consulted the CCAC to provide input on a LTC home that would be the best fit for this study. The researcher initially attempted to recruit a LTC home in the Hamilton region through telephone and e-mail requests. Unfortunately, the administrators of these LTC homes often did not reply to these requests. The next plan of action was to visit the LTC homes in person. The researcher visited eight LTC homes in Hamilton and provided the administrators with a recruitment flyer that contained a brief description of the study (see Appendix A). This recruitment flyer was accompanied by a

letter of reference from the researcher's supervisor (see Appendix B). The management at one LTC home expressed their interest to participate in the study. In addition, management from another LTC home expressed their interest in the study. However, management from the firstly mentioned LTC home followed through with their interest in the study and agreed to participate.

Case Description

The LTC home is located in metropolitan, Central Southern Ontario. It is a non-profit charitable organization. The home has between 250-400 beds, and over 300 staff members (approximately 200 of these staff work in the PSW department).

The management of this home voluntarily submit to external third party review by Accreditation Canada, Commission on Accreditation and Rehabilitation Facilities as well as the CCAC, receiving the highest available accreditation rankings from each organization. The home has also received awards from the local newspaper for a number of years recognizing it as the best long term care home in the Hamilton region. The researcher evaluated and investigated the role that cultural competence plays in the LTC home's high reputation.

Although this LTC home has a faith based focus, the staff also provides the residents with multi-denominational services. Older adults from any ethno-cultural background are welcome to live at the home. A unique characteristic of LTC home is the "Philosophy of Care", which promotes the residents right to live at the home while maintaining their dignity and autonomy. In doing so, the resident's life prior to living at the home is valued and taken into consideration.

Participants

For this study, the DOC and 5 PSWs were recruited to participate. The DOC was requested to participant in a key informant interview while the PSWs were requested to participate in two focus groups for this study. Among the various staff departments in a LTC home, PSWs provide the most direct and frequent contact with the residents. Albeit this factor, PSWs have been considerably understudied in academic research. Therefore, the PSWs are the primary focus of this study. PSWs employed at the LTC home were selected to participate in focus group interviews. The DOC was selected to participate in a key-informant interview. In conjunction with the nurses, the DOC provides guidance and supervision in ensuring that the PSWs fulfill their professional duties. The researcher asked the DOC to provide the current organizational policies and conditions as well as her own views about the role of cultural competence among PSWs in a LTC home.

Recruitment Method

The researcher sent a letter of invitation (see Appendix C) to the DOC to participate in a key informant interview. A follow-up phone call was made after the letter was sent. In addition, the researcher requested the DOC to provide all PSWs with letters of invitation in the PSWs' staff mailbox to participate in one of the focus groups (see Appendix D). This invitation letter included the researcher's contact information. Any PSW who wished to voluntarily participate in a focus group for this study were encouraged to contact the researcher, and were accepted until a maximum for 12 participants were recruited. Providing an invitation letter to all PSWs eliminated bias (Casey & Krueger, 2009), since every PSW had an equal chance to participate. Also, the

distribution of letters equally provided every PSW with any information about the research study.

Since a LTC home is a very hectic institution, and the role of a PSW is highly demanding with limited free time during work hours, the researcher originally planned to conduct the focus group after their work hours. The researcher was mindful of the PSWs' shift schedule and thereby planned to conduct them in a manner that does interfere with those timings. Since there were two separate shifts for the PSWs at this home, two separate focus groups were planned be conducted after the morning shift or before the afternoon shift.

The researcher's initial goal was to recruit at least 10 PSWs to participate in the focus groups. Although she was persistent in her attempts to recruit participants by visiting the LTC home several times, this was a challenging goal to accomplish. After providing each PSW with an invitation letter in their staff mailbox, the researcher anticipated to hear from the PSWs on their willingness to participate in a focus group. Unfortunately, the researcher did not receive any responses from the PSWs prior to the scheduled timeline to conduct the focus groups. The researcher felt it was best to go to the home and visit each home unit to provide the PSWs with another letter of invitation in person. After receiving permission from the unit managers, the researcher also visited the home units during the PSWs' unit meetings to remind them of the study. When speaking with the PSWs in person, it appeared that conducting a focus group between shifts or after work hours was not a viable option for the PSWs because most of them were unable to participate due to other commitments that occurred outside of their work hours. Such

commitments included medical appointments, family related obligations, and other part-time jobs.

After learning this information, the researcher eventually negotiated with the DOC to schedule focus group sessions during work hours. The disadvantage to this change was that the focus group sessions would need to last for half an hour long as opposed to an hour at the minimum. Despite these efforts, recruitment remained challenging. Although PSWs were granted permission to leave the floor for half an hour, they expressed reluctance to do so. Since there are only two PSWs working on each floor for 25 residents, a difficulty would be posed on the PSWs and the residents if there was only one PSW working on the floor. The responsibility for one PSW to take care of 25 residents is one that was justifiably avoided. Having learned these constraints on the PSWs' work conditions, the researcher felt that a communal lunch break would be an ideal time to conduct a "lunch-time focus group." However, the researcher soon learned that PSWs at this home do not have a communal lunch break. This unexpectedly difficult recruitment process provided the researcher with a firsthand observation of the extent to which PSW staff positions need to be increased. The researcher was also given the opportunity to take a glance at the hectic work and life conditions that some PSWs faced even before speaking with them. Upon completion of the first two phases of data collection, the researcher was eager to hear the PSWs' voices so that these initial impressions could be validated.

Data Collection

One of the characteristics of a qualitative case study is the use of multiple sources of data to answer the research questions (Merriam, 2009). The multiple sources of data

were used to provide a holistic picture of the selected case. In this research study, the data were collected in three phases, in the following order: 1) document analysis, 2) key informant interview, and 3) two focus groups.

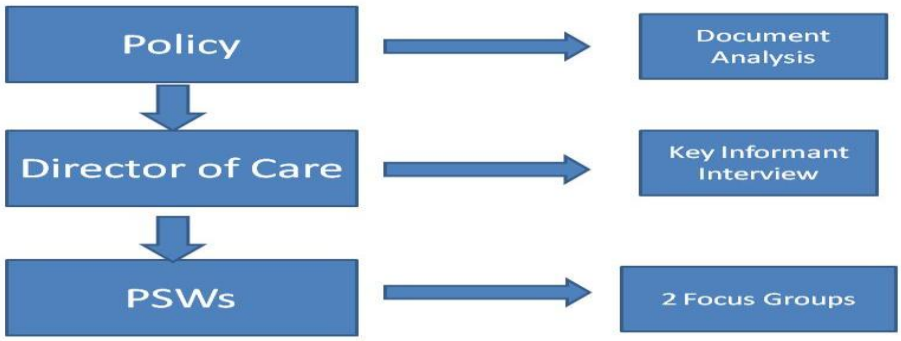

Figure 4. Data Collection Process

As displayed in Figure 4, the researcher investigated the LTC home's policies through a document analysis. Once the researcher gathered and analyzed the information from the selected policy documents, the researcher conducted a key informant interview with the DOC. Lastly, the researcher conducted two focus groups with 5 PSWs. The collection of data from multiple sources helped the researcher gain an in-depth and holistic view of cultural competence in the home from both the organizational and individual perspectives. The following subsections will provide more detail on each phase of data collection.

Phase 1: Document Analysis

The researcher analyzed the following policy documents at the LTC home: 1) The Residents Bill of Rights, 2) Mission Statement, 3) Vision Statement, 4) Values Statement,

5) the home's Philosophy of Care, 6) Hiring Policy, and the 7) PSW Job Description. These policies and principles function as the foundation, standards, and expectations for the successful organizational operation. The objectives of the document analysis are as follows:

1. To learn about the organizational goals based on these policies.
2. To learn about the expectations for the PSW staff employed at the LTC home.

These two objectives guided the researcher to her search for specific information that helped to answer the research questions. Any new themes from the analysis of the policy documents that emerged while conducting the key informant interview were incorporated into the focus groups guides. The key informant and focus group guides were modified in order to incorporate these emergent themes.

Phase 2: Key Informant Interview

Interviews are an effective method to retrieve information on an individual's feelings or interpretations of the world around them (Merriam, 2009). The researcher conducted a key informant interview with the DOC in order to gain an understanding of her perceptions of cultural competence. Prior to conducting the interview, the researcher requested the DOC to sign a consent form (see Appendix E). The following main areas were explored in the interview: 1) Organization, Practice, and Policies 2) Perception of Culture and Cultural Competence and 3) Future Prospects (see Appendix F). This data source added concrete information about the current conditions and organizational expectations of culturally competent care and for the PSWs working at the LTC home.

The key informant interview was audio-recorded and transcribed. In addition, the researcher recorded handwritten notes throughout the course of the interview as a means to monitor her own thought process and initial impressions of the session.

Phase 3: Focus Group Interviews

The researcher selected the focus group method in order to learn about the PSWs' shared experience and meaning of cultural competence as well as their perceived needs and barriers at the LTC home. Conducting a focus group encouraged the PSWs to "consider their own views in the context of the views of others" (Patton, 2002, p.386). The intent of the focus group was for the PSWs to stimulate each other's responses and be active in group discussions (Casey & Krueger, 2009). Ideally, the researcher aimed to conduct the two separate focus groups with 5-6 participants in each group from each shift. However, the researcher caught a glimpse PSWs work conditions and how they affected the researcher's ability to achieve this goal. In the first focus group, one PSW was present to participate. In second focus group, four PSWs were present to participate. The second focus group was scheduled after the researcher transcribed and analyzed the data from the first focus group. Although there was one PSW participating in the first focus group, this session was still classified as a focus group due to the incorporation of the second focus group. According to Casey and Kreuger (2009; 2), the focus group method involves conducting more than one focus group session as a means to "identify trends and patterns in perceptions." In addition the second focus group provided the researcher with the opportunity to follow up with themes and comments from the first focus group (Casey & Krueger, 2009).

The goal of the focus group is not to reach a consensus, but to focus on the conversation between the participants (Casey & Krueger, 2009). The researcher paid close attention to the responses from the PSW participant in the first focus group and the conversation between the participants in the second focus group so that she could probe the participants' responses when necessary. These probes arose from the contents of the discussion among the participants. Both focus groups were audio recorded and transcribed. In addition, during each focus group, the researcher recorded memos of the general themes that were perceived by the researcher. This procedure aided the researcher to pick up any additional themes she may have missed while conducting the focus groups.

The researcher designed focus group questions that were intended to facilitate the conversation (Casey & Krueger, 2009). At the beginning of each focus group, the researcher explained the purpose of the study, ground rules for group discussion including confidentiality and their rights during the focus group. Then, she asked the participants to sign the consent form as well as to complete a brief demographic information survey (see Appendix G and Appendix H). This demographic survey involved information on the individual characteristics of the participants, including their cultural and religious background, years of employment at the LTC home, and previous training that may be related to cultural competence. The following three areas were explored in the focus groups: Work Conditions and the Environment of the LTC Home, Cultural Competence: Everyday Practice and Experiences, and Future Prospects: Promoting Cultural Competence and Training Expectations (see Appendix I). The focus group contained broad and open-ended questions, allowing for all participants to have an

equal opportunity to speak and provide a variety of responses. The contents of the focus group interview guide provided the PSWs with the opportunity to discuss cultural competence in a naturalistic setting (Creswell, 2007).

The researcher was mindful of the fact that the nature of the focus group method has the potential to negatively impact the quality of the data. In preparation for these potential problems, the researcher devised a plan in order mitigate the occurrence of any potential problems (see Appendix J). Although the researcher made diligent attempts to remind the potential participants to attend the scheduled sessions that they agreed to attend, by making follow up phone calls, there were instances in which no participants showed up. Thus, the researcher was pressed to continue recruitment until PSWs were present at the focus group sessions. However, the researcher valued her organized and meticulous approach to this data collection method so that she could successfully conduct the focus groups.

Data Collection Guides

The researcher created preliminary guides for each phase of data collection. These guides were developed on the basis of Suh's (2004) model of cultural competence. For the document analysis phase, the researcher used the concepts in Suh's (2004) model as sensitizing concepts. The researcher then investigated whether the policies can be related to the terminologies used in Suh's (2004) model. For example, any information that provided an indication of "cultural awareness" in the policy documents was highlighted and analyzed. In the key informant interview and focus group guides, the researcher asked her participants broad questions related to the terminologies related to Suh's (2004)

model. Since this model was directed toward nursing practice, the researcher investigated how applicable this model of cultural competence was to the PSWs' work conditions.

While being attentive to the emergent nature in designing a qualitative research study, (Creswell, 2007; Merriam, 2009) the researcher was open to changing the preliminary guides for collecting the data. The objectives for the document analysis as well as the key informant and focus group guides were subject to change as the researcher progressed through each data collection phase. This openness to change was due to the fact that the researcher developed new insights and questions during each phase that were incorporated into the next phase of data collection.

Data Analysis

In qualitative research, the data analysis process begins when the data collection starts. In other words, data analysis was conducted throughout the data were collection period and then continued on a more intensive level once all the data were collected (Merriam, 2009). This simultaneous data analysis process, also known as the constant comparative method (Merriam, 2009), is necessary, given the emergent and flexible nature of a qualitative research design. While using this method, the researcher incorporated any new or emergent insights into the key informant interview and focus group guides. Conducting data analysis during and between data collection phases encouraged the researcher to consider other areas that needed to be explored in the next phase of data collection. As a result, the researcher was able to gain new information and constantly compare, test and validate the findings from three separate data sources

(Merriam, 2009). Figure 5. provides an illustrative explanation how this constant comparative method was used in the study.

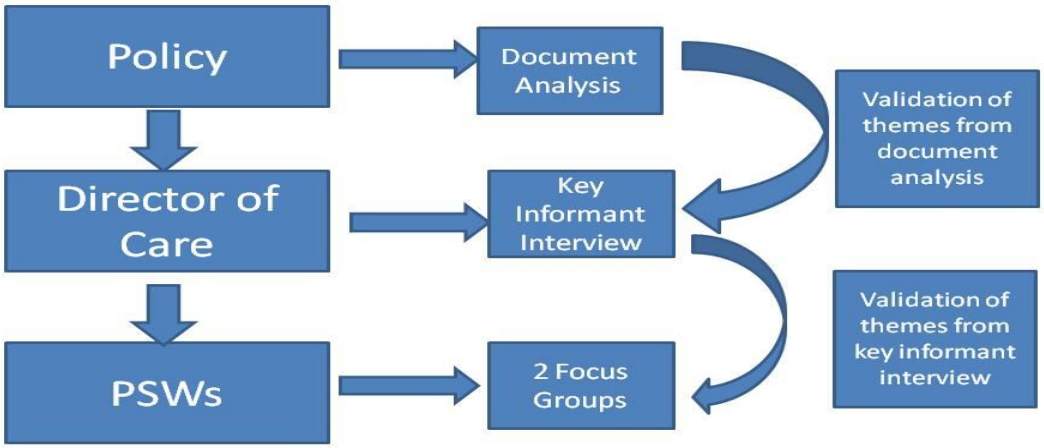

Figure 5. Constant Comparative Method

More specifically, when the researcher found unexpected themes and questions while analyzing the policy documents, she incorporated these questions into her key informant interview guide. If some other unexpected themes from documents arose when the researcher listened to the responses from the DOC, she added new questions that were related to these themes into focus group guides.

One of the challenges of qualitative analysis is keeping a focus on the study's purpose (Casey & Krueger, 2009). Qualitative data analysis has strengths to find out new and unexpected themes generated from the data as well as to confirm the existing concepts found in literature review that are called "sensitizing concepts" (Creswell, 2007). At the same time, however, the rich and detailed qualitative data may divert the

researcher from her focus. Therefore, the researcher followed Merriam's (2009) step-by-step data analysis procedures. According to Merriam (2009), data management is an important first step for efficient data analysis. The database must be organized in a manner that makes each data source easy to retrieve. In order to achieve this, the researcher systematically assigned a number to each data source and stored them in separate folders as the data accumulated. The researcher made a list of the data sources to keep as an inventory of the selected documents, key informant interview transcript, a list of initial themes recorded from the memos, and the audio tapes and transcripts of the focus groups. The organization of each data source helped the researcher to conduct both her initial and intensive analyses, during and after the data collection (Merriam, 2009).

Merriam (2009) recommends three steps of coding: open, axial, and selective. Although this approach to coding was originally created by Strauss and Corbin (1990) as a qualitative data analysis tool for a "grounded theory" study, Merriam (2009) has noted that this systematic data analysis approach is useful for any type of qualitative research, including the case study approach. The following subsections will explain how each coding step was used.

Open Coding

During this phase, the researcher was open to any themes that arose from the data sources. Strauss and Corbin (1990) state that there are three variations of conducting open coding, which are based on how the codes will be created: 1) line-by-line analysis, 2) a sentence or paragraph, or 3) the overall document. The researcher conducted open

coding of her data through means of a line-by-line analysis because it allowed her to conduct an in-depth examination of each data source.

The open-coding process was divided into two phases. The first phase involved a complete "inductive" approach (Merriam, 2009). While reading through each data source line by line, the researcher highlighted any words and phrases that represented a concept or feeling that was connected to the topic of this study (Merriam, 2009). Then the researcher assigned code names to these words and phrases and wrote the code in the left margin of the transcript. These code labels captured distinct meanings or concepts that summarized the particular portions of the data.

The codes were grouped into categories based on the similarities and common characteristics between the themes (Merriam, 2009; Strauss & Corbin, 1990). Each category contained codes that shared similar characteristics and were named in a manner that appropriately summarized the commonalities among the codes.

Axial Coding

Once the categories were constructed, the researcher compared of the nature of each category in order to determine any relationships among the categories. This procedure is known as "axial coding" (Merriam, 2009; Strauss & Corbin, 1980). In order to help her accurately interpret the meanings the categories, the researcher created matrices which consist of properties and supporting quotations in each category.

Selective Coding

In the last stage of analysis, the researcher conceptualized and explained the paramount relationship between the categories (Merriam, 2009). Once the relationship

was identified, the researcher created a diagram to visually demonstrate the relationship between the core category of cultural competence and other related categories. The researcher compared this final conceptual diagram that emerged from the LTC home to Suh's (2009) conceptual framework to further discuss the similarities and differences. The researcher suggested any additions that may need to be incorporated into Suh's conceptual framework (2004) in order to make it relevant to PSW practice in the LTC settings.

In summary, the data analysis process of this qualitative case study was generally inductive. Although Strauss and Corbin's (1980) three steps of coding was originally used for analyzing a "grounded theory" study, this data analysis procedure helped the researcher successfully condense the detailed data into a more conceptual level. In addition, the procedure also facilitated her ability to draw a practical as well as theoretical conclusion on cultural competence among PSWs working at the LTC home.

Pilot Test

In order to check the relevance of the questions and wording used for the key informant and focus group interviews, the researcher planned to conduct mock interviews with a DOC and a couple of PSWs who work in another LTC home. The DOC of this home was able to participate in the mock interview. Although the researcher made attempts to request their participation for pilot testing the focus group guides, PSWs from another LTC home were unavailable to provide their time to participate.

The main objective for conducting this procedure was to determine whether the interview and focus group guides needed to be modified. The researcher saw the benefit in practicing on a mock sample before speaking with the actual participants of the study.

Casey and Krueger (2009) list three main reasons to omit a question: 1) participants are silent or look baffled, 2) participants verbally express their confusion with a question, and 3) participants' responses may not answer the question. The researcher kept this criterion in mind while conducting the pilot test with the DOC. Any questions that fit this criterion were marked with an asterisk as a reminder to omit or rephrase the question from the actual research study. The pilot test aided the researcher to remove any jargon or terminologies that may be unclear to the participants.

Strategies to Ensure Validity of Findings

In order to make her case study as rigorous as possible, the researcher incorporated the three strategies "trustworthiness", "consistency", and "transferability" to increase the validity of findings and analysis.

Trustworthiness

"Trustworthiness" is the terminology that is the qualitative equivalent to the concept commonly known as "internal validity" (Merriam, 2009). According to Merriam (2009), there are five major ways to ensure the trustworthiness of findings: 1) triangulation, 2) member checks, 3) adequate engagement, 4) reflexivity, and 5) peer examination. The remaining paragraphs in this subsection described how the researcher used each method of trustworthiness.

According to Merriam (2009), there are four types of triangulation that increase the authenticity and validity of the findings of the study: a) the use of multiple methods, b) multiple sources of data, c) multiple investigators, or d) multiple theories. The researcher incorporated the first three types of triangulation into her study through

analyzing the data collected through three different data sources (documents, key informant interview, focus groups) with close consultation with her thesis supervisor and committee members.

Since the researcher was the key instrument of data collection and analysis in qualitative research, it is possible for her to make some mistakes in recording and interpreting participants' responses (Merriam, 2009). In order to mitigate this possibility, two "member checks" were conducted. The researcher conducted a) a member check with the DOC to validate the responses, and b) a member check with the focus group participants. Once the responses from the key informant interview were transcribed, the researcher sent the transcript to the DOC and asked her to make any corrections, changes, and additions that may have been necessary. The DOC confirmed that no changes were needed to the transcript. In addition, the DOC also clarified some of the responses that were questionable to the researcher. The researcher also sent a copy of the focus group transcripts to the PSW participants in order to verify their responses. They provided their approval on the transcripts. Prior to conducting the second focus group, the researcher met with the PSW participant from the first focus group to receive her approval on the transcript. She read the transcript during one of her breaks and provided her approval by signing the transcript with her initials. After the researcher conducted the second focus group, she asked the PSW participants if they would provide their approval and feedback on the focus group transcript. The participants were all in consensus that they did not have the time to report their feedback but were comfortable with the idea of providing advanced approval. In the process of conducting the member checks the PSW

participants from both focus groups stated that they did not have time to report their feedback on the researcher's emergent questions or interpretations.

According to Merriam (2009), adequate engagement involves "purposefully looking for variation in the understanding of the phenomenon" (p.219). This research design did not include a prolonged observation of the LTC home due to the researcher's time constraints. However, she aimed to establish a good rapport with participants in order to create an environment that is comfortable and engaging for the participants. In establishing a good rapport with the participants, the researcher did the following: a) reminded the participants that all information was kept confidential between the researcher and the participants and also between the participants, and b) actively listened and probed when appropriate. These steps allowed the researcher to gain adequate information through the interviews and focus group discussion.

Reflexivity relates to the researcher's personal standpoint and biases that may influence the results and analysis of the study (Merriam, 2009). It is important for a qualitative researcher to identify and acknowledge these factors in order to be conscious of their influence on her interpretation. More detail will be provided on the researcher's reflexivity in a later section of this chapter.

The peer examination procedure involved the consultation with fellow researchers who have greater expertise and experience with topics related to the research study (Merriam, 2009). The researcher consulted with her supervisor and committee members on her data analysis in order to validate whether her interpretations of the data were correct. In turn, this procedure served as a form of researcher triangulation.

Consistency

In quantitative research, "reliability" refers to whether the same findings could be found if the study was repeated. However, in qualitative research, the context-sensitive nature makes it impossible to replicate the exact same study in other settings (Merriam, 2009). On the other hand, the results of a study should be not be discredited (Merriam, 2009). It is in fact possible to find consistency among the findings in a qualitative manner if the study was meticulously conducted with a standardized qualitative design and procedure that incorporates "triangulation", "peer examination", "reflexivity", and the "audit trail" (Merriam, 2009). In the "audit trail" procedure, the researcher kept a detailed journal that contains information on the process of data collection and analysis in order to monitor herself and report her progress to her supervisor (Merriam, 2009).

Transferability

Transferability refers to the concept commonly known as external validity. In order to verify the transferability of the study, the researcher provided a "thick description" of her case (Merriam, 2009). Patton (2002) noted that a thick description involves thoughtful sequencing, appropriate use of quotes, and context clarity so that the reader joins the researcher in the search for meaning. Since this research study is intended to serve as a resource for LTC staff in Ontario, it is hoped that staff from various LTC homes in Ontario will learn something from the case of LTC home in order to determine whether the findings from the study can be transferred and applied to their practice setting.

Reflexivity

The researcher, who is a Muslim Bangladeshi and was raised in the Niagara region, is closely connected to this topic due to her experiences of racial and cultural misunderstandings. The scarcity of ethno-cultural diversity in her environment meant that many residents of the area were unaware of the cultural differences that defined her lifestyle. For example, teachers and students in her elementary school were unaware of her religious restrictions against eating pork products and the researcher was unnecessarily excluded from events like school pizza days. In more recent years, the researcher experienced a cultural misunderstanding in the healthcare setting. When waiting in the hospital for the birth of her niece, she observed instructions which were labeled as "Hindi", when in fact they were written in Bengali. The researcher believes that such misunderstandings and mistakes can be avoided with increased cultural competence. It is the researcher's hope that this study will contribute to promoting positive change in LTC delivery. While conducting her research, the researcher hoped that the collaborative qualitative data collection methods, such as key informant interview and focus groups, provided opportunities for the participants to reflect upon their own perception and practice of culturally competent and person centered care.

Ethical Considerations

Since this research study involved the use of human subjects, the researcher submitted her ethics review application to the Brock University's Research Ethics Board (REB) and received ethics clearance from both the REB and LTC home to conduct her study (see Appendix K).

The researcher received informed consent from all participants in the study by requesting them to sign a consent form (see Appendix G and Appendix E). This procedure enabled the participants to be informed of every facet of the research study, including the goals, research design, and any potential risks or benefits that may be present (Kvale & Brinkmann, 2007). Furthermore, informed consent allowed the participants the right to withdraw from the study at any point during the data procedure (Kvale & Brinkmann, 2007).

Also, confidentiality was ensured in the data collection procedure. Although it is challenging to ensure the complete confidentiality, the researcher requested that all focus group participants discuss the contents of the focus group within the research setting. All information gathered from the data collection phases remained strictly confidential, while all raw data was solely accessed by the researcher and her thesis supervisor.

According to Kvale and Brinkmann (2007), "the ethical principle of beneficence means that the risk of harm to a participant should be the least possible" (p. 73). This research study was intended to generate more potential benefits than harms. A foreseen psychosocial risk was that focus group participants may have felt pressured to participate in the focus group due to the fact that their DOC provided the letter of invitation to solicit their participation. In addition, focus group participants may have felt obligated to make positive remarks about their place of employment and practice in order to avoid the loss of their reputation among their fellow employees. In order to mitigate any of these potential risks, the researcher requested that the DOC provide every PSW in the department with letter of invitation to the focus group. Therefore, the DOC did not select the PSWs to participate in the research study. The voluntary nature of participation in the

study allowed the PSWs at the home with the freedom to contact the researcher to express their interest in the study. Participation or non-participation in the focus group did not influence their future work conditions or relationships with their managers. This matter was clearly explained to the focus group participants in the oral explanation, informed consent letter, and letter of invitation.

When conducting an interview or focus group, the researcher made every attempt to collect information that is rich in content. However, given the potential psychological and social risk facing PSWs, the researcher was mindful of Kvale and Brinkmann's (2007) statement that "the personal closeness of the research relationship puts continual and strong demands on the tact of the researcher regarding how far to go in his or her inquiries" (p. 73). Therefore, the researcher was sensitive to the nature of her probing questions while conducting the interview and focus groups.

Conclusion

The amount of thoroughness and rigour involved in following the methodological guidelines in this study determined the quality and progress of the remainder of this study. The researcher used these guidelines as a reference point with this factor in mind. The next chapter presents the results that were extracted from utilizing the aforementioned qualitative research methods and methodological approach chosen for this study.

CHAPTER FOUR: FINDINGS

Introduction

The focus of this chapter is to present the findings on the perceptions and practices of cultural competence among PSWs in an Ontario LTC home. The key findings include that the multi dimensional concept of "culture" perceived by the PSWs. "Culture" is perceived as a concept that transcends ethno cultural and linguistic differences between healthcare providers and recipients in the LTC home. While the word "cultural competence" is not directly used in the LTC home, the policy documents and the stories from the DOC and PSWs indicated that cultural competence is actually practiced in a manner which is similar to person-centered care. The work environment in the LTC home plays a role in the PSWs' practice and perceptions of culturally competent care.

These findings were derived from the analysis of all of the three data sources. As described in the previous section, the data analysis included three steps. First, each of the three data sources was analyzed separately in order to find the major categories. Once this open-coding procedure was complete, the second step was to determine the overarching themes. For the third step, the researcher conceptualized cultural competence of the PSWs in the context of the LTC home by determining the relationship among the overarching themes. As the final product of the data analysis process, a diagram was developed to visualize the concept, while comparing it to Suh's (2004) conceptual framework of cultural competence. Sensitizing concepts from the conceptual framework were used to determine the meaning that PSWs give to cultural competence in the context of this LTC home. The following sections presents the step by step process of how these

results were found, while providing "thick description" of the PSWs' anecdotes and experiences in the LTC home. In addition, at the end of the chapter, the researcher will summarize the findings in a manner that provides the answers to the study's research questions.

Step One: Findings from Three Data Sources

Data Source 1: Policy Documents

Following the data collection plan, the researcher first reviewed and analyzed five policy documents. Analysis of the policy documents fulfilled the following two objectives:

1. To learn about the organizational goals of the LTC home.
2. To learn about the expectations for the PSW staff employed at the LTC home.

These seven policy documents were: 1) The Resident's Bill of Rights, 2a) The Mission, 2b) Vision, 2c) Values, 3) the Philosophy of Care, 4) The Hiring Policy, and 5) The PSW Job Description. The Resident's Bill of Rights was developed by the MOHLTC based upon the Ontario LTC Homes Act in 2007. This document provides standardized guidelines to LTC homes across Ontario. The remaining documents that were used for this study were developed by the LTC home.

Organizational goals of the LTC home: findings related to objective 1.

While all seven documents were useful, the Mission, Vision, Values, the Philosophy of Care, and the Resident's Bill of Rights documents in particular, helped the researcher understand whether and how cultural competence was included as a goal in the

organization . The researcher compared the four in-house documents (the Mission, Vision, Values and the Philosophy of Care) with The Resident's Bill of Rights to determine how the LTC home followed the guidelines of The Resident's Bill of Rights within the unique context of the home.

Following open-coding of each document, the researcher classified her codes into three major categories: the residents, staff, and the LTC home environment. These three categories encompass the components of a LTC home. In addition, the categories overlap with the three domains of outcomes of cultural competence in Suh's (2004) conceptual framework (i.e. outcomes of cultural competence for providers, receivers, and the overall healthcare organization). Table 1. presents a list of the categories and sub-categories pertaining to the five documents.

Table 1. Organizational Goals of the LTC Home

Categories	Sub- Categories
Staff	• "Excellence in Care" * • Meeting The Needs of Residents • Respect • Leadership
Residents	• Choice • Dignity • Privacy • "Participate in the Life of the LTC Home" *
Environment	• Supportive Environment • Use of Available LTC Home Resources

* Direct quotations from the document

As this table suggests, there are specific goals for the staff, residents, and the environment of the LTC home. The staff are required to provide "excellence in care" by meeting the needs of the residents, show respect and be respected, and utilize leadership skills. As a result of fulfilling these expectations, the residents are expected to have the opportunity to maintain their ability to make choices, maintain their dignity, maintain their right to privacy, and "participate in the life of the LTC home" (Resident's Bill of Rights, LTC Homes Act, 2007). The LTC home environment is required to be supportive to both residents and staff and enable "efficient use of available LTC home resources" (Values statement). While none of the documents explicitly described what these resources were, these categories clearly suggest that the fulfillment of these expectations are goals toward achieving optimal operation of the LTC home.

Expectations for PSWs: findings related to objective 2.

Among the seven documents, the Hiring Policy and the PSW Job Description were helpful to learn about the expectations for the PSWs' role and work conditions at the LTC home. Table 2. presents a list of the two major categories and sub-categories that emerged from these documents.

Table 2. Expectations For the PSWs

Categories	*Sub- Categories*
Hiring Process	• Current Staff's Adherence to Hiring Philosophy • Potential Staff's Fulfillment of Application Requirements • Interviewing Potential Employees • Discussion of Qualifications and Expectations With Potential Employees • Requirements of New Employees Before Working at the LTC home
Requirements of PSWs	• Personality Traits of Potential PSW Staff • Educational Requirements • Fulfillment of Duties • "Work in a Safe and Healthy Manner" * • Attendance at In-Service Educational Opportunities Offered at the LTC home

* Direct Quotations From The Document

When hiring, all managers at the home are required to adhere to a hiring process in accordance with the LTC home's hiring philosophy and application requirements. The selected applicants are invited to an individual interview in which the applicants discuss his or her qualifications. Once a decision has been made, new employees are required to provide results from a health examination and a Vulnerable Sector Screening Check prior to commencing employment at this LTC home. During the interview process, the current LTC home staff require prospective employees to describe how they will exhibit specific personality traits, such as leadership and compassion, towards the residents. PSWs in particular are expected to perform their designated duties in a "safe and healthy manner"

(PSW Job Description). Lastly, the educational opportunities are provided to them as means of enhancing their professional skills and knowledge.

Through the document analysis, the researcher learned a lot of background information about LTC home's ideals before directly collecting data from the DOC and PSWs. However there were some limitations of this process. For example, the researcher could not find any direct reference to the words "cultural competence" in any of these documents. The initial impressions of the documents prompted the researcher to learn more about the context and extent to which these polices are integrated into practice. Based on the emergent themes from this phase of data analysis, the researcher incorporated new questions that emerged from the document analysis into the key informant interview.

Data Source 2: Key Informant Interview

The DOC, age 38, has been working for the home in this position for six years. She started working at the LTC home in 1991 as a Registered Practical Nurse. Her educational background is Diploma Registered Nurse at a university in Australia. She works closely with other departments including social work, program services, and food services in the LTC home. As the head of the Nursing Department, she is responsible for the department's budget. She is responsible for 378 residents and 375 nursing staff comprised of RNs and RPNs; her team consists of five RN unit managers. These unit managers are responsible for the PSWs who work in each of the five home units. The DOC stated that she directs the PSWs by encouraging all PSWs to be leaders at this LTC home. She feels that the leadership skills are highly emphasized within the PSWs' scope

of practice. The DOC provided the researcher with her view of cultural competence among the PSWs within the context of the LTC home.

Table 3. presents a summary of the six major categories and sub categories that emerged from her responses.

Table 3. Categories from Key Informant Interview Responses

Categories	*Sub-Categories*
Description of the Home	• Large Home • Environment of the LTC home
Role of the DOC	• Directing the PSWs • Communication with Other Departments • Managing the Budget
View of Cultural Competence	• Connection Between Organizational Policies and Cultural Competence • Definition of Cultural Competence • Relevance of Cultural Competence to PSWs • The Needs of the LTC Home • Connection Between Cultural Competence and Person Centered Care • Strategies to Promote Cultural Competence Among PSWs
PSW Work Conditions	• Encouragement to Utilize Leadership Skills • Increasing Need for PSWs • Provide a Homelike Environment for Residents • Communication Between PSWs and Other Staff Members • Providing Care to the Residents Through Required Duties
Available Resources in the LTC home	• Multi-Cultural Staff • "Faith Based Home"* • Collaborative Hiring Procedure • Resources to Improve Staff Performance • In-Services for PSWs
Limitations of the LTC home	• Language Barriers among Residents and Staff

	• Limited Funding • Time Barriers for PSWs • Inconsistency of Care
Suggestions for Improvement	• Extra Funding for more PSW Staff Positions • Consistency of Care between PSWs and Residents

* Direct Quotation from Interview Responses

The 90 minute in-depth interview with the DOC provided the researcher with details about the concept and practice of cultural competence in the LTC home, the PSWs' work conditions, the LTC home environment including available resources, the limitations of the LTC home and her suggestions for improvement based on these limitations. In addition, she also clarified most of the questions that emerged from the document analysis. However, some questions still remained unanswered. For example, the DOC found it difficult to provide information on the ethno-cultural composition of the residents. She noted that it was difficult to answer this question because of the home's large size. The researcher surmised that this information gap may be attributed to the nature of the DOC's work role. The researcher felt the need to hear the voices of the PSWs. Since they provide direct care to the residents on a daily basis, they would be able to offer first-hand information about the environment and cultural competence practice at the LTC home.

Data Source 3: Focus Groups

For the third phase of data collection, the researcher conducted two focus group sessions at the LTC home with a total of 5 PSWs. The first session consisted of 1 participant. The second session consisted of 4 participants.

The five PSW participants who agreed to participate in this study were full-time staff who worked in the same home unit. All participants were female and their ages ranged from 40-50 years of age. All participants had been working at the LTC home for an average of 20.5 years. One participant stated that she held another part-time job outside of the LTC home. Two of the participants identified themselves as Canadian. The remaining participants were immigrants from England, Jamaica, and the Philippines. In addition to speaking English, one participant from the Philippines speaks Tagalog.

Six major categories emerged from the responses in the two focus groups. These categories are presented in Table 4.

Table 4. Categories From Focus Group Responses

Categories	*Sub- Categories*
Work Conditions	• Busy • Time Limitations • Lack of Knowledge of Residents' Needs • In-Services • Differences Between Day Shift and Evening Shift • Fulfilling Duties
View of Cultural Competence	• Unfamiliarity with the term • Diverse Staff and Residents • Communication With Other Departments • Providing Various Church Services • Showing Respect Towards Residents and Staff • Creating a Culturally Competent Environment
Interactions with Residents	• Building a Rapport with Residents • Recognition of Resident's Life Before Moving into the LTC Home • Continuation of Cultural Practices • Noticing Changes in Residents • Negative Experiences with Residents • Delegating Tasks Between Staff Members
"Here for the Residents"*	• Fulfilling the Residents' Needs • Providing a Homelike Environment for The Residents
Suggestions for Improving the LTC Home	• LTC Home For Younger Adults • Provide More Opportunities to Learn About The Residents • Improving In-Services

∗ Direct Quotation from Focus Group

As Table 4. shows, the focus groups with the PSWs provided rich and contextualized informationn from the PSWs during the two focus groups. The first focus group provided

the researcher with the opportunity to gain insights from an individual PSW's perspective while the second focus group allowed her to gain group insights and observe the group dynamics and collaboration among the PSWs. During the second focus group, PSWs were collaborating with one another to build and enhance the quality of their responses. Although the group dynamic was not present in the first focus group, the researcher viewed this session as an opportunity to gather insights from an individual PSW's perspective. While all 5 PSWs in both groups seemed to be equally open to providing responses, the researcher noticed the slight difference in the tone of their responses between the individual and the group setting. These differences enabled the researcher to hear some possible conflicting views and group dynamics that exist among the PSWs on issues that need to be addressed in this large LTC home.

Step 2: Overarching Themes across the Three Data Sources

After completing the initial open-coding of the three data sources, the researcher advanced her analysis into the second step of axial coding. Through the comparison of major categories and sub categories as presented in Tables 1. through Table 4., the researcher developed five overarching themes across three data sources. Because the first step involved an inductive approach, this second step involved a deductive approach by paying closer attention to the key concepts of the conceptual framework in order to determine what cultural competence means to the PSWs and how it is practiced in the LTC home. Table 5. presents a list of the overarching themes and sub-themes.

Table 5. Overarching Themes and Sub-Themes

Overarching Themes	*Sub-Themes*
The Culture of The LTC Home	• Culture as a Multi-Dimensional Concept • Holistic Approach to Care • Cultural Competence in Daily Practice • Cultural Composition of Residents and PSW Staff
Provision of a Supportive Environment	• "Destination of Choice"* • Preservation of Autonomy among Residents and PSW Staff • "This is the Residents' Home"*
Collaborative Team Approach to Care	• Collaboration Between PSWs • Collaboration Between PSWs and Other Staff Departments • Collaboration Between PSWs and the Residents and Their Family Members
Building a Relationship With The Residents	• Consistency of Care Among PSWs • Recognition of the Residents' Lives Before Moving to the LTC Home
Maintenance of Staff Morale	• Meticulous Hiring Process • In-Services and Educational Opportunities

* Direct quotations

The following sections will present a description of each overarching theme with the sub-themes included. Quotes will be used to support the findings in this research study. The PSWs participants' names will be replaced with pseudonyms as a means to protect their identity. Code numbers will be placed in bold print next to each quote and will be used as reference points in a table that illustrates how the researcher compared some of these themes with key concepts of the conceptual framework used in the study.

Overarching Theme 1: The Culture of the LTC home

There are four sub-themes that define the culture of the LTC home. These themes were the "Culture as a Multidimensional Concept", "Holistic Approach to Care", "Cultural Competence in Daily Practice", and "The Cultural Composition of the Residents and PSW Staff." Every one of these elements is necessary to define the culture of the LTC home.

Culture as a Multi-dimensional Concept

As the first step to understand "cultural competence" in the LTC home, the researcher searched for the meaning of "culture." The Resident's Bill of Right's document (LTC Homes Act, 2007) mentioned the word culture in its opening statement. The statement highlighted that "[the residents'] physical, psychological, social, spiritual and cultural needs [must be] adequately met" (Resident's Bill of Rights, **1A.1**). Further into The Resident's Bill of Rights document (LTC Homes Act, 2007) the researcher found more words associated with the concept of culture.

> Every resident has the right to pursue social, cultural, religious, spiritual and other interests, to develop his or her potential and to be given reasonable assistance by the licensee to pursue these interests and to develop his or her potential (Resident's Bill of Rights, **1A.2**)

The researcher interpreted the words "social", "religious", "spiritual", and "other interests" as different dimensions that comprise the concept of culture. As this statement suggests, helping residents pursue their various personal interests for their development in the later stage of life is an essential part of care delivery at LTC homes. Following the analysis of this government document, the researcher searched for similar patterns in the in home's policy documents in order to determine the consistency between The

Resident's Bill of Rights (LTC Homes Act, 2007) and the goals that were specific to the LTC home. The Philosophy of Care document provides a similar pattern with the statement: "all residents will live a life that has spirituality" (Philosophy of Care, **1A.3**). In addition, the researcher found a few other terms, such as "individual uniqueness", "lifestyle", "nationality", and "customs of residents" were associated with the concept of culture in the Philosophy of Care document. Bringing these two documents together, it is clear that "culture" in the LTC home is not narrowly defined by ethno-cultural differences but rather by diverse individual and personal interests and needs.

Holistic Approach to Care

The researcher found that this broad definition of culture is closely associated with the holistic approach to care that is mentioned in the Values statement. According to this policy document, the LTC home staff aim to take a "holistic approach" (Values, **1B. 1**) in order to meet the diverse needs of the residents.

To contextualize this "holistic approach" into the residents' everyday life, the researcher asked the DOC to provide more information on how this approach was incorporated in everyday practice. Having briefly mentioned the importance of the spiritual aspect of care, she described her view of holistic approach in the following way: "I think it's just looking at everything for the residents in regards to their goals, their current condition, their hopes and beliefs so that we can try and meet them as best as we can" (DOC, **1B.2**). As the DOC explained, the holistic approach encourages the staff to be sensitive to the each resident's various needs as a person. The words "goals", "hopes",

and "beliefs" are broader terms that allow for LTC home staff to learn about the each resident's individual needs.

In the same vein, the PSW Job Description document also describes the concept of the holistic approach within the context of PSW practice. The PSWs are required to "provide [s] cognitive, social and emotional support to residents" (PSW Job Description, **1B.3**). The PSW Job Description clear suggests that this LTC home views social and emotional support as essential elements of the holistic approach and culturally competent care.

Cultural Competence in Daily Practice

The third sub-theme of this 1st overarching theme is the definition of cultural competence and how it relates to everyday practice. Both the DOC and the PSW participants noted that the term is not often used in daily practice of the LTC home. Nevertheless, in response to the researcher's request, they described what it might mean in the context of their daily practice.

The DOC described her view of "cultural competence" in the following way:

> Competence to me is the ability to provide a task, having the knowledge, the skills, and the judgment perhaps in order to be confident in that skill. The cultural piece is just for what your beliefs are, what country of origin you came from, and those types of things (DOC, **1C.1**).

The words "knowledge", "skills", "judgment", and "confidence" provide some context to the PSWs' practice and the DOC's expectations for the PSWs working at this LTC home. Interestingly, while the DOC defined cultural competence, she placed emphasis on the term "competence." This may be reflective of her role as a manager and her expectations for the PSWs.

In contrast, when the PSW participants discussed their perceptions of cultural competence, their focus was geared to the concept of culture. They provided many concrete examples regarding their knowledge of residents' diverse needs and lifestyles. The PSW participants described culture with the words "lots of colours, languages, ways of doing things, thinking about things" (Angela), "beliefs, food, where they were born, how they dress" (Catherine), "sometimes they wear a veil" (Abigail),"Mrs. L. has a cap that she has on, she has her hair braided" (Catharine) **(1C.2).** Concepts such as age, sexual orientation and, mental health status were identified as part of the residents' culture. For example, one PSW participant stated: "we deal with different people, like schizophrenia and bipolar as well as a lot of ethnic [people]" (Catharine, **1C.3**). While this statement overlaps with the aforementioned multi-dimensional concept of culture of the LTC home, the researcher learned concrete details about the many different aspects of life that are considered in the concept of culture based on the PSWs own practice at this home. According to the PSW participants, being culturally competent means being knowledgeable about each resident's diverse needs and accommodating this knowledge into daily practice.

Cultural Composition of Residents and PSW Staff

The fourth sub-theme of the "Culture of the LTC Home" involves the cultural composition of residents and staff in the LTC home. The LTC home's hiring philosophy entails a broad spectrum of equal opportunity and respect for the diversity of beliefs and lifestyles of their residents and workforce.

> [The LTC home] shall grant equal employment opportunities to all qualified persons without regard to race, ancestry, place of origin, colour, ethnic origin,

> citizenship, creed, sex, sexual orientation, age, record of offenses (for which pardon has been received and exceptions those disclosed by a Vulnerable Sector Reference Check search), marital status, family status, or handicap (Hiring Policy, **1D.1**)

The Hiring Policy also notes:"We believe that the [LTC home] is enriched by a diverse resident community and workforce and that all persons deserve respect in their diversity of beliefs and lifestyles" (Hiring Policy, **1D.2**). As the researcher expected, the documents did not contain content on the cultural backgrounds of the residents and staff. Therefore, the interview and focus groups helped the researcher find out more details of this "diverse resident community and workforce."

As mentioned previously, the DOC was uncertain of the cultural backgrounds of the residents. The PSW participants' responses suggested their close connection to the residents through their work role. They said that they have cared for residents from Germany, Portugal, Italy, Greece, Jamaica, Bosnia, and Africa. These specific examples indicate knowledge of the residents' cultural backgrounds. When the PSW participants were asked about the religious backgrounds of the residents, one participant simply stated: "well I know they have different churches here" (Catharine, **1D.3).** These concrete descriptions given by the PSWs suggest the PSWs' knowledge about the residents' cultural background through their daily exposure. However, the PSW participants also commented on their limited knowledge of the residents' backgrounds. One PSW participant attributes this limited knowledge from not having "the chance to know the residents here" (Angela, **1D.4**). Also she stated that the PSWs "don't get to see their charts and what their history was" (Angela, **1D.5**).

Both the DOC and PSWs mentioned that they are aware of the diversity among the staff. They stated that there are many PSW staff from the Philippines, Jamaica, and a small number of staff who were Canadian born. The advantage of multi-cultural staff is reflected in the DOC's description of the translator list. She stated: **"**It does benefit to have [the translator list]. We have a large employee base which is 550 for the [home]. So we sometimes come across [a language barrier] but we seem to manage it internally with the staff" (DOC**, 1D.6).** As this quotation suggests, multi-cultural staff members serve as a resource that offers translation services, in effect, enhancing the quality of care.

In summary, culture is defined as a multi-dimensional concept at this home and includes elements such as spirituality, ethnic background, sexual orientation, geographic location, and age. The holistic approach used at the home emphasizes the sensitivity to each resident's needs and contextualizes how the DOC and PSW participants put this definition of culture into their practice. In addition, the culture of the LTC home is also defined by the cultural composition of the residents and staff. It appears that the distinctive aspect between the DOC's and PSW participants' knowledge of the residents' backgrounds is based on the nature of their work roles and their direct interaction and care with the residents. Both the DOC and PSWs are knowledgeable of the diversity among the staff. This knowledge can be attributed to the fact that the PSWs and DOC frequently communicate with each other.

Overarching Theme 2: Provision of a Supportive Environment

The second theme that emerged from the comparison of the three data sources is a supportive environment provided to both residents and PSW staff. In this LTC home, a supportive environment is comprised of three elements: "Destination of Choice",

"Preservation of Autonomy among Residents and PSW Staff", and "This is the Resident's Home."

"Destination of Choice"

The overall vision for this LTC home is to make it a "destination of choice for Seniors, an employer of choice for staff and volunteers" (Vision, **2A.1**). The PSW participants recognize that older adults and their family members show feelings of reluctance towards living in a LTC home and a sense of sympathy is reflected in their opinions. "They didn't choose to come to a point where they had to be fed, they had to be changed, where they are just lying in a bed and they can't even converse with you" (Catharine, **2A.2**). The PSW participants recognize that the residents are not their former selves due to their deteriorating health. The DOC surmised that a consequence of delaying the move to the LTC home is that "the care levels in LTC are heavier" (DOC, **2A.3**). Consistent with the DOC's statement, a PSW participant placed this issue into the context of her own practice. She stated that the residents "come to us in a really bad condition and there are so many care needs to deal with" (Angela, **2A.4**). The use of the words "so many care needs to deal with" imply an anticipated stressful environment inherent within any LTC home perceived by residents, family members, and staff.

Nevertheless, the DOC's and PSW participants' response also suggested that this LTC home is making an effort to attract potential residents, through the availability of various cultural resources for the residents. One of the examples provided by the DOC is a chapel. "Our residents want to come [to the home] to live because of the chapel so that they continue their faith whatever that may be (DOC, **2A.5**)." As this response indicates,

this LTC home has created a supportive environment where residents and family members can maintain their lifestyle with comfort, by making some cultural resources accessible and available to all residents.

The LTC home appears to be one that is a supportive environment for its staff members. One of the indicators of this level of support is the long duration of employment of focus group participants averaging 20.5 years of employment. Both the DOC and PSWs stated that there were a number of long term PSWs who had worked in the home for 20-25 years. Also, they said that switching between the day shift and the night shift allows them to gather "a fresh perspective "and "notice changes in the residents" (Angela**, 2A.6**). PSWs are granted the opportunity to work on another home unit if a job opportunity becomes available. This opportunity enables the PSWs to gain new experiences with other residents and enhance their skills and desire to continue working at this LTC home.

Preservation of Autonomy among Residents and PSW Staff

The second element which contributes to a supportive environment of the LTC home is the "autonomy" among residents and staff. However, due to the nature of their role at the home, this autonomy has differing meanings for the residents and the PSW staff.

The residents' autonomy is exercised through the opportunity to "make choices they are still able to make" (Philosophy of Care, **2B.1**) and the opportunity to raise concerns about the quality of care they are receiving thorough the "strong Family Council and Resident's Council" (DOC, **2B.2**) at this LTC home. Residents are provided with the

freedom to make choices in regards to their religious practices, dietary, and clothing preferences. The DOC stated that the home offers an array of religious services to various faith groups. The home also has an extra refrigerator in each unit so that family members could bring food for the residents who have diverse dietary needs.

However, the PSWs' lack of knowledge of the residents needs stifle the residents' autonomy. One PSW participant expressed how the lack of knowledge of the residents' needs limits the residents' ability to continue their religious practices. She said: "there are so many church services offered here and we just have to know which type of services they want to go to" (Angela, **2B.3).** This PSW participant expressed the fine line between fulfilling the expected protocol of care and meeting the individual needs of the residents.

In order to ensure autonomy among the staff, a leadership approach to care is encouraged among all staff. The LTC home requires PSWs and all other staff to "have leadership that fosters a supportive environment (Philosophy of Care, **2B.4**). The DOC defined the leadership approach between her staff as one that "engage[es] the employees rather than having that authoritarian approach" (DOC, **2B.5**). The execution of these leadership skills was also displayed in the following quotation:

> I've had one of the girls talk to the manager and a female resident expressed that they wanted to be shaved down there and the girl says "I'm not doing that, I'm not doing that." And the unit manager says "well don't you already do that?" And that's when you step in and say "you know what? I'll go do it." That's usually how it's managed. You have to use your own judgmen**t** (Catherine, **2B.6**).

The idea of "using your own judgment" displays a sense of leadership in the decision making process among the PSWs. Also, the PSWs feel encouraged to express their

discomfort with performing a certain task. As a result, a problem becomes known and is then collectively solved with the support from other staff.

"This is the Resident's Home"

The third sub-theme of this overarching theme is the shared notion among the staff that "this is the resident's home" (PSW participants, **2C.1**). In particular, the PSW participants repeatedly mentioned that they are "here for the residents" (PSW participants, **2C.2**). A number of elements seemed to contribute toward creating this homelike environment for the residents.

First, the personalized environment is a key factor that offered comfort to the residents in their new home environment. The DOC described that a culturally competent environment creates a "living space" (DOC, **2C.3**) for the residents. This concept of a "living space" echoed from the PSWs' opinions. In their view "music (Christine, Abigail), "decorate[ing] their room" (Catherine), and "cultural pieces" (Mary)**(2C.4)** from their previous home create this homelike environment. These responses from the PSWs provided the researcher with a picture of the residents' lives and their personal preferences in their home environment as well as the PSWs' experiences with the residents. The vivid descriptions of residents' home environment implied the PSWs' attentive care for each resident.

The LTC home's Philosophy of Care indicates that "all residents will live a life that has spontaneity and variety as well as structure" (Philosophy of Care, **2C. 5**). This means that staff members are required to keep a balance between spontaneity and

structure. The following example of one PSW's experience with a resident vividly illustrates this intricate balance:

> I had a gentleman that said "I was in Africa for awhile and we had to layer. I know it makes you hot but this is what my body is used to." And he was in his room sweating. We wanted to put an air conditioner in his room, he put his foot down. No way was he [going to have one], but he needed it. But he was sweating to the point where he was actually quite ill. But because this is what he was used to, he didn't want to change. So that's something we had to monitor quite close, because he would get dehydrated (Catharine, **2C.6**).

In this example, spontaneity is related to the resident's cultural preferences and his desire to be in a home environment. Also, the procedure of monitoring the resident's condition contextualizes the issue of "structure" while enabling "spontaneity" to the resident's needs.

Privacy is another key factor for the residents in the LTC home environment. The DOC expressed a strong statement that resonated well with the researcher. She mentioned: "often we have to remember that we're working in their home, they're not living in our workplace" (DOC, **2C.7**). This statement eloquently summarized the purpose of a LTC home. Provision of this privacy is particularly important when a resident's death is near. "Reflection rooms" (DOC, **2C.8**) are available for family and residents during this intimate time. One PSW participant also illustrated how this privacy is respected when she said: "we try to make this their home as much as possible. If a resident tells us that we're in their way, we listen and we get out of their way" (Angela, **2C.10**).

Residents at this LTC home are encouraged to "form friendships and relationships and to participate in the life of the LTC home" (Resident's Bill of Rights, **2C.11**). One PSW participant explained that the dining room and the living room are places where

residents are welcomed to socialize. The opportunity to form friendships is open to all residents "no matter what culture [the resident] is from" (Catherine, **2C.12**). However PSW participants also observed that there is limited interaction between the younger and older residents in the LTC home.

> When you talk about culture and that it's true about aging, we've come to the point where we have 50 year olds sitting with 90 year olds (Catharine)- And what do they have in common? (Mary) So it's like a cultural age gap? (Researcher) Yeah (Mary**,** *the rest of the participants nod*) (**2C.13).**

This excerpt of the focus group also indicates that the PSWs see the age difference among the residents as a cultural gap, well overlaps with the aforementioned concept of the multi-dimensional culture in the LTC home due to the recognition that "age" is a part of the concept of culture.

Overall, the three major dimensions of "Destination of Choice", "Preserving Autonomy among Residents and Staff", and "This is the Residents Home" comprise a supportive environment for the residents and staff. Creation of the homelike environment in this LTC home seems to be closely related to culturally competent practice in which the residents' personal needs and cultural difference are well accommodated. The supportive environment also allows the PSWs to use their own judgment and leadership to a certain degree within their structured practice. While some limitations have been addressed toward creating a completely supportive environment, there is more quality evidence that yields the impression of a supportive environment.

Overarching Theme 3: Collaborative Team Approach to Care

The third theme emerged from all three data sources is the collaborative team approach to care that enables the PSWs to practice culturally competent care. This team

approach has been divided into three types of collaboration:"Collaboration between PSWs", "Collaboration between PSWs and Other Staff Departments", and "Collaboration between PSWs and the Residents and Family Members."

Collaboration between PSWs

A common finding is that PSWs would collaborate with each other in order to solve a problem. The DOC noted that when a problem arises, they are required to "talk within their team" (DOC, **3A.1**). Regarding cultural competence, the DOC stated that she encourages her staff from diverse cultural backgrounds to learn from each other. The PSW participants also stated that they have "enough" (Christine, **3A.2**) exposure to cultural groups through their interactions with other staff. As an example of their collaboration, one participant shared her experience with their problem solving skills in a culturally competent manner, through her experience with a resident who would not allow a non-Caucasian person come into her room. "So whoever her [the PSW's] partner is, they just switch" (Mary, **3A.3**). Interestingly, this anecdote suggests not only the effort among PSWs to respect the resident's preferences, but also the avoidance of a potential "cultural clash" between the resident and PSWs.

The factor which limits this level of collaboration is the insufficient staffing. One PSW participant states that "2 PSWs to 25 residents is not enough. We need the chance to get to know the residents**" (**Angela, **3A.4**). Since each resident has varying levels of care, the chance to learn about the residents' individualized needs becomes less likely when the home has insufficient staffing.

Collaboration between PSWs and Other Staff Departments

When problems cannot be solved between the PSWs, they are required to turn to other staff departments for assistance. As outlined in the PSW Job Description, PSWs are required to "Communicate[s] effectively with the resident, nursing staff, and care team" (PSW Job Description, **3B.1**). The DOC also described the chain of support that is available to the PSWs when trying to solve a problem. She says:

> [The PSWs] would likely go to the registered staff working on their home area and try and problem solve that way. If that was unacceptable, they may call social work or a unit manager to problem solve around that (DOC, **3B.2**).

This DOC's description was consistent to the PSW participants' description of collaborating with the PSW staff, registered staff, or the Social Worker when assistance was needed in problem solving. The PSW participants approached the issue by asking "did you notice that?" (Catherine, **3B.3**) when inquiring about the changes in a resident's behavior or health condition. In asking this question, the PSWs inquire about the level of knowledge and experience that other staff departments have with the residents.

The DOC noted that collaboration between staff departments occurs frequently because of "limited resources" (DOC, **3B.4**) and the "teams have to rely on each other" (DOC, **3B.5**). However, this limitation was described with an optimistic tone. The DOC also explained that the increased collaboration between staff departments provides an opportunity for PSWs to enhance the quality of their practice and learn new skills. The focus group discussions revealed that there is a lack of collaboration between the PSWs and the Social Worker. PSW participants have mentioned that they were allotted the time to collaborate with the home's Social Worker to learn preliminary information on every

new resident who moved to the LTC home. The PSWs were unsure why this procedure had been eliminated, despite its benefit for the PSWs.

Collaboration between PSWs and Residents and Family Members

The residents and their family members are entitled to be involved in the residents' care through collaboration and providing their feedback on the quality of the care. As stated in the Resident's Bill of Rights (LTC Homes Act, 2007): "Every resident has the right to have any friend, family member or other person of importance of the resident attend any meeting with the licensee or the staff of the home"(Resident's Bill of Rights, **3C.1**). In the DOC's opinion, this level of collaboration is another means by which the PSWs define her expectations. She says:

> They're expected to carry out their job, they're also expected to work with families, work with residents, deal with complaints, and be a leader within their own team, communication skills. Those [skills] need to be specialized very so that they can function as part of the team" (DOC, **3C.2**).

As this comment indicates, the DOC views collaborating with the residents and family members as an essential part of a team approach to provide high quality care.

The PSW participants also briefly mentioned that they can also learn about the residents' dietary needs when the family members bring food from home. However, the PSWs' limited elaboration on this the topic lead the researcher to speculate that the collaboration with family members may be less common.

Collaboration enhances the PSWs' skills and knowledge of the residents, which in turn enhances their culturally competent practice. Generally, PSWs utilize the first two types of collaboration as methods for solving problems. The most effective way to learn about the residents' needs is by gaining information from the social worker, family

members, and the residents themselves. However, PSWs do not seem to have enough time to spend with a social worker, residents, or family members in the manner they wish due to the insufficient staffing.

Overarching Theme 4: Building a Relationship with the Residents

Despite the challenges such as insufficient staffing and the lack of a formal information sessions about a new resident, the PSWs stories also implied that they had been building a relationship with the residents. Through this process, the PSWs learn about the residents' needs or culture. The foundation of this relationship is built upon two major elements "Consistency of Care among PSWs" and "Recognition of the Residents' Lives before Moving to the LTC Home."

Consistency of Care among PSWs

"Consistency of care" refers to residents receiving care from the same PSWs on a consistent basis. This consistency of care fosters the residents' trust and comfort with their care providers. The residents are entitled "to be told who is responsible for and who is providing the resident's direct care" (Resident's Bill of Rights, **4A.1**). According to the DOC, consistency of care yields positive results for both the resident and the PSW. When consistency of care is provided to the residents by the PSWs, "[the residents] don't need to explain their routine or what their likes and dislikes are over and over again day after day" (DOC, **4A.2**). In return, consistency of care provides the PSWs "the chance to get to know the residents" (DOC, **4A.3**).

Since the PSWs who participated in this study were full-time staff, they were in a position to provide insight on their experiences of providing consistency of care. The

PSWs explained that the opportunity to "get to know the residents" is incorporated into their daily routine, especially through interaction during meal times or bath time. One participant expressed that these times are essential because "[the PSWs] don't really have time to [get to know the residents] at any other time" (Mary, **4A.4**). Through their experiences, the PSW participants notice the benefits of this consistency of care. "The residents get to know us, they don't like change. We're in the same unit everyday"(Mary, **4A.5**). The researcher interpreted that part of this reluctance to change is attributed to the fact that the move to the LTC home is a change in itself; therefore, residents are looking for a sense of consistency in their lives as a means of adjusting and feeling comfortable in their new home environment.

Emergent from the focus group sessions is that consistency of care also fulfills the expectation for the PSWs to "provide general reference to the changes in the resident's condition" (DOC, **4A.6**). Based on the care that is given on a daily basis by the same PSWs, it is feasible to notice a change in a resident. One PSW described a resident's change in the following manner: "one gentleman we have, sometimes he's quiet, sometimes he'll just walk by and he'll say nothing. He just goes for cigarette after cigarette. Other days he just talks, talks, talks" (Catherine, **4A.7**). This quotation reflects the PSWs' knowledge of the resident's chronic condition through her daily observations. Because of her consistent care on a daily basis, she is able to notice a change in the resident's behavior. In addition, these daily observations of the residents enable PSW staff to build their sensitivity and empathy towards the residents.

> At first you think "oh that person is sick they should just get over it." You know, "quit whining" this and that. But really when you see it daily and you see different people you notice and you think "you know what? It's something they can't get over" (Catharine, **4A.8).**

PSWs understand the intensity of the residents' health conditions due to this prolonged interaction with the same residents.

In relation to the residents' ethno-cultural backgrounds, PSWs notice when residents "regress back" (Christine, **4A.9**) to their native language. PSWs noticed that some residents, who used to speak English when they moved to the LTC home, came to the point where they would only speak their native language. A language barrier was then created between the residents and the PSWs. However, the language barrier can sometimes be breached through the consistency of care that is provided. "There's a language barrier, but you pretty much know what they want in their daily routine, because you're there with them a lot. Then you do gradually understand" (Catherine, **4A.10**). The words "gradually understand" suggest their level of patience and their efforts to acquire the cultural competence necessary to understand the residents' needs.

While consistency of care benefits the PSWs in learning about the about the residents' cultural background and gaining more sensitivity for the residents, other pieces of evidence made the researcher feel that consistency of care may not be happening on a regular basis. She noticed the two main factors that may lead to the inconsistency of care. The first factor is the differences between the day and night shift. The day shift has been commonly known to be "the busiest in terms of time management" (DOC, **4A.11**). The shift is "busiest" because there are two meals in this shift in which PSWs have to ensure that the residents are in the dining room and fed within a particular time frame. Although

care may be provided by the same full-time PSWs on a daily basis, the nature of the care delivery becomes rushed, leaving less time to interact and provide culturally competent care. The second factor contributing to inconsistency of care is the high use of casual PSW staff at the LTC home. One participant noted that in the event of illness or a scheduled vacation, many full-time PSW staff are temporarily replaced by casual or part time staff during that time. A problematic situation is posed for the casual and part-time PSWs who "don't know the floor" (Catherine, Abigail, **4A.12**). Part time and casual staff often feel "frustrated" (Catharine, **4A.13**). One PSW participant described that "[It is] really hard for [the casual PSWs]. Especially if the floor is heavy" (Abigail, **4A.13**). The DOC noted that the inconsistency of care from the PSW staff is something the home is "trying to improve" (DOC, **4A.14**). Improving this aspect of care would allow PSWs to learn about the residents and enhance the quality of the relationship with the residents.

Recognition of the Residents' Lives before Moving to the LTC home

Besides providing consistent care to the residents, PSWs enhance their relationship with the residents by recognizing the residents' lives before their move to the LTC home. PSWs and staff from all departments are required to "recognize[s] and celebrate[s] each resident's individual uniqueness and choice" (Philosophy of Care, **4B.1**). An example of this recognition was first illustrated by a PSWs participant's opinion:

> These people had a job before they retired here. They had a family. You know they got up in the morning, they went to work, they had fun with their family. Now this lady might be nasty now and she's kicking and won't let you get her dressed and she's swearing, but she's a person just like we were before (Catherine, **4B.2**).

This comment encompasses the PSWs' effort to understand each resident as a whole person, including their lives before the LTC home.

The benefit of recognizing and learning about the residents' past experiences helps PSWs to understand the residents' personality traits. A PSW participant explained how this information helped her practice. She stated:

> We would understand why the resident taps his or her foot that way all the time or why a resident moves his hands around like that constantly, it may have had something to do with the job he used to do (Angela, **4B.3**).

While talking about one of the residents who would not allow a non-Caucasian PSW into his room as an example, another PSW mentioned that a resident's previous upbringing may attribute to the reservations that may have. "But that's the way they were brought up. We never know what happened in his life before" (Christine, **4B.4**).

The DOC believed that quality time would enhance a relationship between the PSWs and the residents. This quality time is not defined by the PSWs' tasks. The DOC defined quality time as: "[having] more time to do the social stuff with the residents. To sit down and have a chat, to hold somebody's hand, perhaps take them out for a walk" (DOC, **4B.5**). However, she also added "that seems to be less frequent because of the demands on the care levels without the increased funding" (DOC, **4B.6**). This comment reconfirms the aforementioned problem of insufficient staffing which created greater demands for the PSWs to complete their tasks, leaving less time for the PSWs to build a relationship with the residents.

A good trusting relationship between the residents and PSWs contributes to creating a comfortable living space for the residents and a pleasant working environment for the PSWs. Consistency of care is a key component that builds this relationship with

the residents. The recognition of the residents' lives prior to their move to LTC home is another strategy that PSWs use to understand the residents as a whole person. However, the limitations of high use of casual staff and routine orientated nature of care hinder the ability to build a relationship with the residents.

Overarching Theme 5: Maintenance of Staff Morale

The 5th and the final theme that emerged from the three data sources is the "Maintenance of Staff Morale." The staff morale is indicative of the quality of care at the LTC home. The LTC home takes a proactive approach in order to maintain high morale of staff through the following two strategies: the "Meticulous Hiring Process" and "In-services and Educational Opportunities."

Meticulous Hiring Process

While reviewing and analyzing the Hiring Policy, the researcher received the impression that the hiring process was one that was conducted in a thorough and meticulous manner. The meticulous step by step hiring process outlined in this policy document provides details and considerations involved in making Hiring Managers and applicants aware of certain factors. Hiring Managers are required to carefully assess their applicants' qualifications and aptitude through an investigation of their "employment history, including related qualifications, skills and work experience, reason(s) for leaving current (or past) position(s), and any gaps in employment history"(Hiring Policy, **5A.1**).In addition, applicants are required to provide health examination results, Vulnerable Sector Screening Check, and information regarding any physical health restraints that may limit the staff member from completing the job (Hiring Policy, **5A.2**).

In the event that applicants are invited for in interview, they are required to review the Mission statement, Organizational Philosophy, Philosophy of Care, the history and overview of the LTC home, the job description, and conditions of employment during the interview. The review of these documents enables applicants to learn as much about the LTC home as much as possible before commencing their potential employment.

The PSW Job Description contained specific requirements for prospective PSWs that were unclear to the researcher during the document analysis phase. As stated in the PSW Job Description, PSWs who were trained from a specific college are preferred to work at this LTC home. The researcher was curious to understand why this specific recommendation was part of the hiring protocol for PSWs. The DOC stated that " the program [is] 18 months as opposed to 4-6 weeks at some of the other private colleges" (DOC, **5A.3)**.As a result, PSWs receive more training. Also, students at this college who are training to be PSWs partake in "more of a practical type of experience" (DOC, **5A.4**). The PSW Job Description stated that PSWs are required to undergo a 45 day probationary period after their initial hire. The DOC explained that it is necessary for the unit managers to determine whether the appropriate PSWs have been hired. She illustrates her high expectation of PSWs in the following way: "We try to hire staff [who] aren't just there for the pay cheque. We try to hire staff who want to be here, who want to make a difference, who want to work in a team environment" (DOC, **5A. 6**).

The interview and focus group data showed that this careful hiring process contributes toward enhancing cultural competence at the LTC home. When asked how PSWs are assessed on their cultural competence levels, the DOC referred to a test that applicants are required to take before their interview. She explained that the test "give[s]

us an idea of their literacy levels without coming out and actually asking them questions" (DOC, **5A.7**). In her view, the PSWs' literacy level is an important factor facilitating culturally competent care. Testing their literacy level is a proactive strategy to reduce potential miscommunication caused by a language barrier between the PSWs and the residents.

In-Services and Educational Opportunities

To ensure that PSWs maintain their qualifications and enhance their skills, they are required to attend in-services and other educational opportunities. The PSW Job Description includes this requirement, stating that PSWs "participate[s] in educational activities, in-service education and share[s] responsibility for maintaining and improving knowledge and skills in care of the elderly" (PSW Job Description, **5B.1**).

In-services and educational opportunities have been highlighted within the policy documents and by the participants as a means of achieving "excellence in care." The home's Vision statement outlines that the staff build on "a tradition of excellence in care [through] research and education" (Vision statement, **5B.2**). The DOC explained that the home maintains excellence in care by "always seeking outside resources" (DOC, **5B.3**) for educational opportunities in order to "create our internal culture, which helps our morale" (DOC, **5B.4**). The in-services and educational opportunities become more meaningful when the PSWs have the desire to learn more. The DOC stated: "it's attitudinal as well. Some people want to learn more. Other people are happy with doing what they're doing" (DOC, **5B.5**). In her view, it is important for PSWs to continuously develop their skills and knowledge as professionals. When the researcher asked if there is

any available in-service training related to cultural competence, both the DOC and PSW participants referred to the "Gentle Persuasive Approaches" (Advanced Gerontological Education [AGE], 2012)in-service provided by the Alzheimer Society. The PSW participants added that this in-service "really teaches us how to interact" (Christine, **5B.5**) and "teaches compassion" (Catharine, **5B.5**). As these comments indicate, the PSWs perceive "interactions" and "compassion" as fundamental components of cultural competence. Another educational resource for cultural competence was the "Spiritual Care Week" (DOC, **5B.6**) that is offered by the home's chaplains and guest speakers who provides information on a certain religion. The PSW participants also mentioned that they have been encouraged to attend in-services that are offered outside of the LTC home. One participant reflected on her experience with a palliative care course that included issues of death and dying in relation to culture.

The DOC and PSW participants believed that the best method to teach cultural competence would be by "working [the content] into everyday practice" (DOC, **5B.7**). The DOC says: "unless [the in-services] make a change with their practice, it's [the new material] not going to be sustainable" (DOC, **5B.8**). She stated that the in-services that offer a hands-on- component are successful because the PSWs learn empathy and in her view the concept of empathy in everyday practice "seems to go a long way" (DOC, **5B.9**). The DOC discussed an example of an in-service that was provided to the PSWs in which they learned what it was like to be a resident living in a LTC home with vision impairment or fine motor skills impairment. The PSW participants also saw the benefit of in-services that integrate content into everyday practice. One PSW participant suggested that it would be beneficial to have "a case study on a resident" (Catharine, **5B.10**) who

belonged to a particular background. She also suggested that "cultural theme days" (Catherine, **5B.11**) may also be helpful for them to learn about different cultures and customs. Through hearing the PSW participants' enthusiastic suggestions, the researcher felt their "desire to learn more." These suggestions can be attributed to the DOC's and PSW participants' beliefs that there is a necessity to learn more about culturally competent care.

The DOC and PSW participants have foreseen a greater need for cultural competence in the future as a result of a potential increase of culturally diverse residents in the Hamilton area. Emergent from the focus groups is the idea that there will be an increase of transgendered older adults. The participants discussed that some PSWs may be uncomfortable with caring for transgendered residents. Their experience with a male resident who "puts on his stockings and high heels before going to bed" (Angela, **5B.12**) was highlighted as an example. However, PSW participants also knew that they must put those reservations aside in order to fulfill their role at the home. As one PSW elaborated: "you're supposed to just give the care to the person for their wants, not what your wants are, but what their wants are" (Catherine, **5B.13**). These comments suggest that PSWs are aware of their own bias and feel a necessity to increase sensitivity towards the residents' diverse needs.

Although the available in-services and educational opportunities are beneficial for the PSWs and residents, limitations are present in the ability to attend the in-services and execute the new skills. One PSW participant expressed that the amount of paperwork required prevented them from always attending the in-services. She suggested that this amount of paperwork is unnecessary because "there is more work for us to do on the

floor for the residents" (Angela, **5B.14**).The DOC admitted that the limited staffing does not always enable the PSW staff to execute their new skills that they learned in the in-services, especially for those PSW staff who work during the more hectic day shift. The DOC suggested that "extra funding" may help the home to have more PSW staff. The researcher interpreted that extra staff members will enable PSWs to provide better quality care with their new knowledge and skills.

The hiring managers carefully select PSW staff who can fulfill the home's goals and expectations through the meticulous hiring process. In order to make sure that the hired PSWs maintain and increase their credentials, in-services and educational opportunities are provided. Overall, these proactive strategies seem to help PSWs maintain their morale as professionals, while motivating them to continue working at the LTC home. However, insufficient staffing and the lack of funding emerged as key barriers toward fulfilling this goal

Step 3: Conceptualization of Cultural Competence of the PSWs at the LTC Home

These five overarching themes and sub-themes are all intertwined, and together they provide a full picture of the perceptions and practice of culturally competent care in the environment of the LTC home. As the final step of her data analysis, the researcher created a diagram to indicate the relationship among these themes. The researcher utilized the selective coding method by selecting the most important pieces of evidence that were relevant to Suh's (2004) model of cultural competence. Since one of the main goals of this study was to explore the concept of cultural competence among PSWs at a LTC home setting in comparison with Suh's (2004) conceptual framework, the researcher

designed her diagram by using the basic framework of Suh's (2004) model as a guiding framework.

Suh's (2004) conceptual framework is composed of three main components: perceived attributes of cultural competence (antecedents), work conditions (attributes), and goals for the organization (outcomes). Each component contained sub-components that added depth to the overall conceptual framework. Table 6. displays how the researcher compared the overarching themes and sub-themes from the present study with the key components of Suh's (2004) model. The code numbers in the left column indicate the quotations that were used in the description of the overarching themes in the previous sections. Extraction of these specific quotes facilitated the researcher's ability to connect these concepts to Suh's (2004) framework of cultural competence.

Table 6. Comparison of Contents from Overarching Themes to the Concepts in Suh's (2004) Framework

	Suh's (2004) Model	Selected Content from Overarching Themes	Code Number (s)
Antecedents	Cultural Awareness	Recognition of the Residents' Changing Needs	4A.9
		Recognition of the LTC home as the Residents' Final Home	2C.1, 2A.7, 2C.8
	Cultural Knowledge	Knowledge of the Residents' Past	4B
		Defining Culture in the LTC home	1A
		Knowledge of the Residents' Personal Preferences	2B.3
	Cultural Skills	In-Services on Cultural Competence	5B.5, 5B.6
		Integrating Learned Skills into Everyday Practice	5B.7
		Confidence in Applying Skills	1A.7
	Cultural Sensitivity	Empathy Toward the Residents	2A.3, 4B.2, 5B.9 , 5B.13
		Respect Toward the Residents	3A.3
		Ensuring the Residents' Privacy	2C.7,2C.8, 2C.10
	Cultural Encounters	Developing a Relationship Between Residents and PSWs	4A, 4B
		Residents Developing Friendships	2C.11
		Awareness of "New" Encounters	2C.13, 5B.12
Attributes	Ability	Multi-Cultural Staff	1D.6
		Problem Solving	3A.1, 3B.2
		In-Services Enhance Skills	5B
	Flexibility	Adjusting to the Residents' Schedule	2C.5, 2C.6
		Team Approach to Care	3A, 3B, 3C
	Openness	"Here For The Residents"	2C.2. 5B.13
		"Participate in the life of the LTC Home" and Make Decisions*	2B.4, 2B.5
		Delegation of Tasks Between PSWs	2B.6

Outcomes	Residents	Maintain Cultural Practices	2A.2. 2B.1,
		Creation of a Homelike Environment	2C
		"Destination of Choice" *	2A.1
	PSWs	In-Service Education Fuels Passion for Work	5B.4, 5B.5, 5B.10, 5B.11
		Leadership Approach to Care	2B.7
		Supportive Environment	2B
	LTC Home	Equal Inclusion of Residents & Staff	1D.1, 1D.2, 2C.12
		"Excellence in Care" *	5B.2

* Direct Quotations

Figure 6. displays the PSW Model of Cultural Competence. The researcher created this diagram as a means of incorporating selected key contents from the overarching themes and subthemes found in this study. The diagram presents an overall picture of the concept and practice of cultural competence perceived by the PSWs, the work conditions creating culturally competent care, and the goals of cultural competence for the residents, PSW staff, and LTC home environment. In addition, the facilitating and hindering factors for culturally competent care are presented in this diagram.

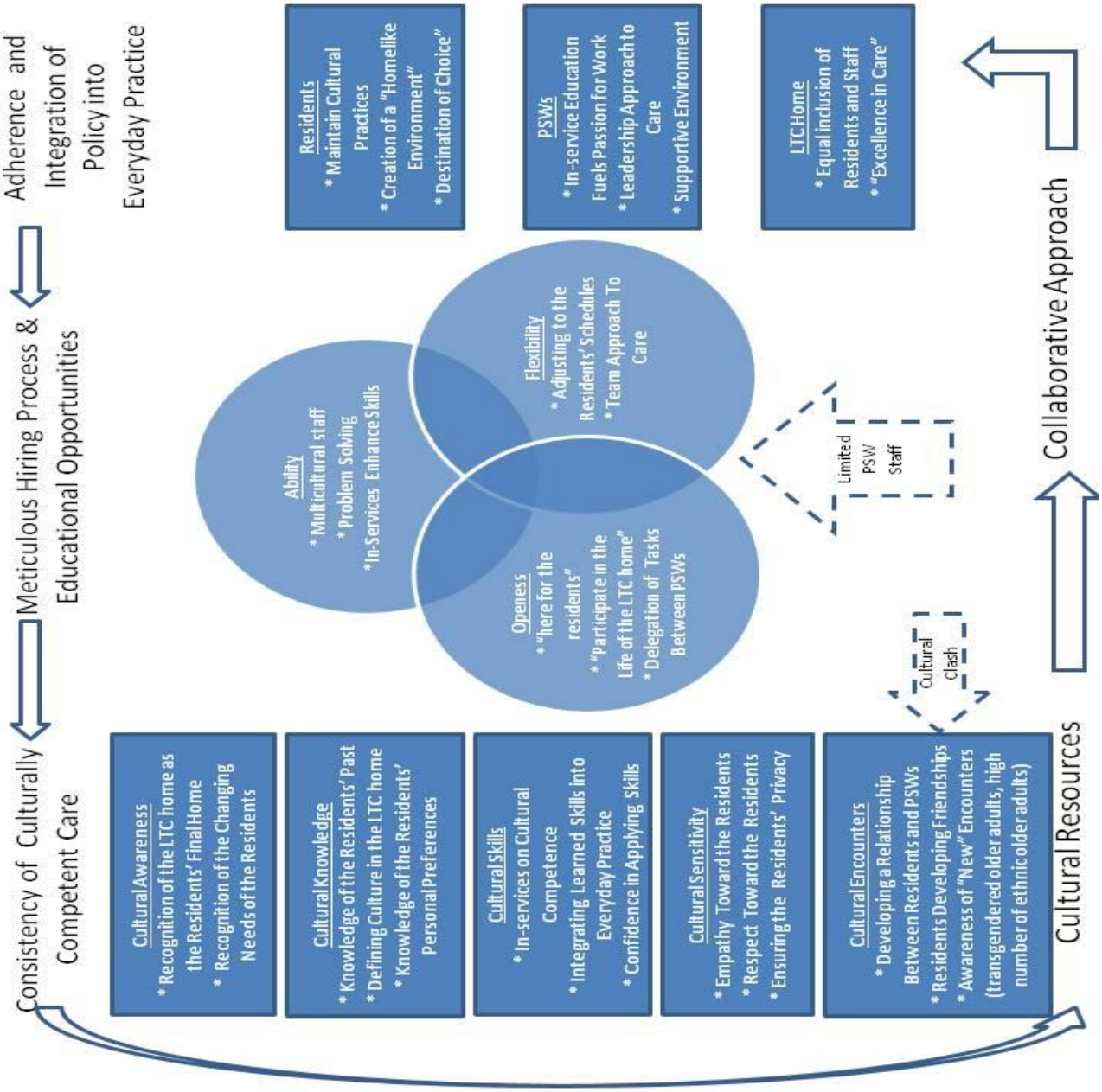

Figure 6. PSW Model of Cultural Competence

- Note: full descriptions of model descriptions are found in Table 7.
- Solid arrows: facilitating factors of cultural competence
- Dotted Arrows: hindering factors of cultural competence

The left side of the diagram (Antecedents) presents the PSWs perceptions on cultural competence in the LTC home. The middle section (Attributes) presents the work conditions that create culturally competent care for the PSWs. The right side of the diagram (Outcomes) presents the intended goals of cultural competence for the residents, PSWs, and the LTC home. Solid arrows indicate the environmental forces in the LTC home that facilitate culturally competent care practice among the PSWs, whereas dotted arrows indicate the hindering forces. Encompassing this model of cultural competence is the cyclical process which strengthens the capacity to deliver culturally competent care. Further detail on this process will be described in the next chapter.

The findings of this case study also suggested the close interrelationship between the PSWs' perceptions and practice of cultural competence, and the environment and policies of the organization. The PSWs' perception and practice of cultural competence are based on the specific environment and goals of the organization. In contrast, the PSWs' daily practice with the residents, family members, and other staff creates and change the environment of the LTC home constantly. Overall, the goal of cultural competence at the LTC home is not achieved through a linear process, but rather a cyclical ongoing daily practice that is determined by the quality of care by incorporating sensitivity and respect for each individual resident's needs. In the next section, the researcher will summarize these findings in a manner that provides the answers to the study's research questions.

Answers to Research Questions

The results of this study led the researcher to the following answers to the research questions.

How do the PSWs and DOC define cultural competence in their everyday practice and work environment?

What are the experiences of PSWs and the DOC in relation to cultural competence?

Although both PSWs and the DOC do not use the word "cultural competence" in their practice, their professional roles and daily practice shape the different experiences of cultural competence. The PSWs' experience of cultural competence is shaped by their interaction with the staff, residents, and residents' families. Since there is not a lot of ethno-cultural diversity among the residents, as far as the PSWs are concerned, the PSWs experience cultural competence through learning about the residents' unique needs and preferences when it is feasible. Also, they have experienced cultural encounters and cultural clashes related to age and sexual orientation. The PSWs also experience culture and cultural competence through their interactions with their culturally diverse co-workers. On the other hand, the DOC experiences cultural competence by looking to hiring staff who can demonstrate the capacity to provide culturally competent care through careful hiring and ongoing in-services. Despite these differences, both the PSW participants and DOC described that cultural competence is experienced through the "collaborative team approach" and person centered care that is encouraged in the organization. In addition, they also described that PSWs practice cultural competence by turning to each other to learn about different cultures and also delegate tasks in order to suit the residents' comfort levels.

How do PSWs and the DOC perceive the meanings of culturally competent care?

There is a difference in the way PSWs and the DOC define culturally competent care. While the DOC focused on the "competence" aspect of the concept, the PSWs focused on the "cultural" aspect of the concept. The reason for this difference may be because of the DOC's expectation for the PSWs to fulfill their work role in a competent manner as well as her limited exposure to the residents. The PSWs perceive cultural competence in relation to the unique needs and preferences of each individual resident, thereby making these perceptions closely related to the holistic approach involved in person centered care.

However, both the DOC and PSW participants perceive "culture" as a multidimensional concept. In this LTC home, religion, age, preferences related to clothing and diet, and sexual orientation were all included in the broader concept of "culture." This factor may be partly because residents at this home are not ethnically or racially diverse. Also, the nature of the PSWs' work role that involves the continuous care for assisting residents' activities of daily living requires for them to understand each residents' needs and preferences that go beyond the medical aspects of care.

What are the current conditions of culturally competent care in an Ontario LTC home?

Are there any policies and resources which promote culturally competent care in an Ontario LTC home? If so, what are they?

Although cultural competence is not explicitly stated in the policy documents, a number of factors outlined in the Resident's Bill of Rights (LTC Homes Act, 2007), the Philosophy of Care, and the Hiring Policy suggest contents that encourage culturally

competent care. The standardized guidelines in the Resident's Bill of Rights (LTC Homes Act, 2007) encourages all Ontario LTC Homes to provide an environment that places an emphasis on a homelike environment that is personalized, ensures privacy, and respect for the residents. Contents of the home's goal outlined in the Philosophy of Care encourage residents to continue their unique culture, and contents of the home's Hiring Policy suggest that a culturally diverse environment of residents and staff is embraced and encouraged. The aforementioned contents of these policies indirectly encourage and promote culturally competent care at this LTC home.

The researcher found that a number of resources and other organizational factors promote culturally competent care. They are as follows: the "meticulous hiring process", multicultural staff, religious resources, the collaborative approach to care, in-service education sessions, a supportive work environment, and the strong Family Council and Residents Council. Following the general trend of LTC homes, this LTC home appeared to emphasize the principle of person centered care within everyday practice. Since the findings of this study draw connections between cultural competence and person centered care, the practices of person centered care also serve as a resource that enhances culturally competent care among PSWs.

What are the challenges and barriers to promote culturally competent care in an Ontario LTC home?

The major challenges and barriers that limit the ability for the PSWs to provide culturally competent care in this LTC home were: limited financial and human resources, inconsistency of care among PSWs due to the high use of casual staff, hectic work

conditions that compromised the PSWs' opportunity to spend time with the residents and learn their unique needs and preferences, lack of time to communicate with residents' family members to learn about the residents' needs, and lack of time to communicate with the Social Worker to access the findings of the residents' initial assessments and learn about the residents' backgrounds. Although in-services were provided and encouraged for the PSW staff to participate and attend, the reality of the situation suggests that PSWs feel they do not always have the time to attend in-services or that they are unable to utilize the new information gained from these sessions because of the task oriented nature of care.

Are there any potential strategies for enhancing culturally competent practice in an Ontario LTC home? If so, what are they?

The researcher found that there are strategies toward enhancing culturally competent practice in an Ontario LTC Home. These strategies toward enhancing culturally competent practice, as stated by the DOC and PSW participants, are focused on providing PSWs with the opportunities to spend more time with the residents.

By hearing the PSWs' voices, the researcher learned about their strong desire to develop a relationship with the residents by learning their needs. In their view developing this relationship through consistency of care is a fundamental aspect toward learning about the residents' unique needs and preferences. Unfortunately, the reality is that PSWs do not have enough time to spend with each individual resident due to the hectic and tightly scheduled work conditions. The DOC also expressed that spending more time with the residents would allow PSWs to learn about the residents' unique needs and

execute their care in a culturally competent manner. Both the DOC and PSW participants suggested that there should be an increase in funding to hire more PSW staff so that culturally competent care and person centered care becomes integrated into everyday practice. Insufficient staffing at the home has been noted to create hectic work conditions for the PSWs. PSW participants stated that when there less staff members to take care of a large number of residents, the PSWs' work routine becomes task oriented rather than person centered. PSW participants also suggested that their large amount of paperwork should be decreased so that more time can be devoted toward having more interactions with the residents. Lastly, the PSW participants stated that it would be beneficial to restore communication and collaboration with the Social Worker at the home so that PSWs can learn more about each resident's unique characteristics.

Conclusion

In summary, the findings from this case study help the researcher contextualize as well as conceptualize the PSWs' perceptions and practice of cultural competence and the environment of the LTC home. One of the unexpected findings of this study is that the word "cultural competence" is not often used in this LTC home. However, the policy documents and the stories from the DOC and PSWs indicated that cultural competence is practiced in a manner that is unique to the home. The researcher also found that the PSWs' cultural competence and practice are not independent from their work environment. The policies, racial composition of the organization, and supportive work conditions play a role in how culturally competent practice is executed and constructed. The use of the three data sources to find overarching themes helped the researcher validate the findings. Overarching themes and the conceptual diagram emerged from the

three data sources drew the researcher closer to understanding the unique nature of cultural competence of PSWs in the LTC home environment. The next chapter will provide connections between relevant literature and the data collected from this study.

CHAPTER FIVE: DISCUSSION

Introduction

In this chapter, the researcher will place the findings of her study within the context of existing literature, and discuss the similarities and differences. More specifically, the researcher will examine the PSWs' perceived meanings of cultural competence found in the PSW model of cultural competence (see p. 107) that was developed from the findings of this study in relation to the major components of Suh's (2004) model. Throughout the chapter, this model will be referred to as the "PSW model." The descriptions will be divided into three sub-sections: antecedents of cultural competence (left column of the models), attributes of cultural competence (middle column of the models), and outcomes of cultural competence (right column of the models). Through these descriptions, the researcher will highlight the meanings of "culture" and the delivery of culturally competent care in the LTC care home, which is shown to be different from Suh's (2004) model of culturally competent acute care. The researcher will also discuss how the concept of cultural competence perceived by the PSWs are related to person centered care. The PSWs' work conditions and role implementation found in this study will be further discussed with reference to the previous literature. The limitations and strengths of the study will be addressed, followed by the implications for further research and practice, and conclusive remarks.

Comparison between the PSW model and Suh's (2004) Model of Cultural Competence

While Suh's (2004) comprehensive cultural competence model (see p. 26) served as a helpful framework for the researcher to identify the components, the process, and the outcomes of cultural competence, the findings of the present case study suggest that

Suh's (2004) model is not sufficiently applicable to the LTC home setting. Since Suh's (2004) model mainly focuses on the process of cultural competence at the individual health practitioner level, it fails to include the organizational or environmental factors (resources, work conditions, role of management, and culture in the health care organization) that could facilitate or hinder this process. The findings of the present case study highlight that Suh's (2004) model presents an idealistic view of cultural competence because of the omission of these details that may hinder or facilitate the process of cultural competence. In addition, the concepts found in the PSW model of cultural competence acknowledges that "culture" is a broad concept that goes beyond ethnic or language differences.

Description of Antecedents of Cultural Competence among PSWs

The researcher acknowledged that there were some differences between the five antecedents of cultural competence between Suh's (2004) model and the present study's PSW model . These antecedents include "cultural awareness", "cultural knowledge", "cultural skills", "cultural sensitivity", and "cultural encounters." They are located in the left column in Suh's (2004) model and the PSW model . Table 7. compared the meanings of the five components between both models.

Table 7. Comparison of Antecedents of Cultural Competence (CC)

	Suh's (2004) Model	PSW model	Meanings of CC Perceived by PSWs
Cultural Awareness	Awareness of the Need for Cultural Competence	Recognition of the Residents' Changing Needs*	The residents' changing needs are recognized by the PSWs over time due to their long stay at the LTC home (such as reverting back to their native language). Throughout the process of providing assistance with residents' activities of daily living, PSWs' constant and frequent contact with the residents helps them to become aware of the fact that this LTC home may be their final home. Thus, the PSWs would like to provide a homelike environment that suits the residents' individual needs. PSWs perceive cultural knowledge in relation to the residents' individual preferences based on their understanding of the residents' lives before moving to the LTC home. Knowledge of the LTC home's culture plays a role in cultural knowledge through identifying the residents' and staff members' cultural backgrounds. PSWs find this type of personal information to be a valuable asset toward meeting the residents' unique needs.
	Awareness of Own Culture and Cultural Biases	Recognition of the LTC Home as the Residents' Final Home *	
	Understanding Diverse Cultures & World Views	Knowledge of the Residents' Past*	
	Learning Historical, Economic, Social, and Political Factors that Influence Culture	Defining Culture in the LTC home	
		Knowledge of the Residents' Personal Preferences*	
Cultural Sensitivity	Respect for Cultural Differences	Empathy toward Residents*	Mindfulness of these three factors of empathy, respect, and privacy foster sensitivity toward the residents' dignity.
	Acceptance of Diverse Cultures	Respect toward Residents	
		Ensuring Residents' Privacy*	
Cultural Skills	Cultural Data Assessment	In-Services on Cultural Competence	The types of skills that can be learned at in-services are similar to person centered care. PSW participants described that the content of these in-services allows them to learn skills to provide care for residents in an empathetic and compassionate manner. The added element that the present research study incorporates is the process involved in implementing the skills required for cultural competence.
	Cultural Physical Assessment	Integrating Learned Skills into Everyday Practice	
	Intercultural Communication	Confidence in Applying Skills	

Cultural Encounters	"Cultural Immersion"	Developing a Relationship between PSWs and Residents Awareness of "New" Encounters	PSW participants acknowledged the current and future "new" encounters between younger residents and transgendered residents. Awareness of these "new" encounters transforms and broadens the concept of culture that goes beyond ethnic and language differences. Cultural encounters are not solely between the residents and staff. The need for residents to make friendships highlights the importance of social interaction in a home environment. Cultural encounters are also related to PSWs' encounters with residents' family members. These interactions help PSWs to learn about the residents' diverse needs.
	Nurses Interactions with Patients from Differing Cultural Backgrounds	Residents Developing Friendships with Other Residents*	

* Content related to a home environment

As shown in Table 7., the major distinguishing factor between the contents of Suh's (2004) model and the PSW model of cultural competence is the differing nature of care between acute care and LTC home settings. The meanings of the five antecedents, as perceived by the PSW participants, suggested the nature of their practice. The PSWs' continuous assistance with the residents' activities of daily living raises their consciousness that the LTC home is the residents' final home. Suh's (2004) model does not yield any content related to a home environment because acute care settings are generally designated toward short-term visits. In addition, Suh's (2004) model was developed for nurse practitioners in the context of the medical model of care. Due to the fact that PSWs in the LTC home mainly provide regular assistance with residents' activities of daily living in the social model of care (CBOC, 2011; CIHI, 2006; Lilly, 2008; MOHLTC, 2011; Stone, 2004), PSWs also view the "home like environment" as an essential component of culturally competent care because it helps to maintain the residents' well-being and quality of life.

Unlike Suh's (2004) model, the findings of this case study also suggest that "culture" is perceived as a concept that goes beyond ethno cultural and linguistic differences between healthcare providers and recipients. The PSW participants' stories revealed that "culture" in their home is not limited to "customs", "practices", "beliefs" (Easton, 1999; RNAO, 2007),"race" (James, 1996),"ethnicity" (Maville & Huerta, 2002), or "immigration status" (Boyd & Vickers, 2000).The numerous dimensions of "culture" described by the PSW participants confirmed that "culture" is in fact a broader and relative concept as noted in previous literature (Easton,1999; Mitchell, 1995; RNAO; 2007). PSW participants referred to "culture" based on their knowledge and experiences

of some residents' preferences related to clothing, dietary choice, and the available religious resources at the home.

The findings of this case study also revealed that age and sexual orientation should be considered when providing culturally competent care, which are also components of culture that RNAO (2007) acknowledged. The PSW participants' bewilderment when interacting with younger residents and transgendered residents contributes to the existing literature related to cultural clashes that occur in LTC homes (Brandler,2000; Chan & Kayser-Jones, 2005; Gnaedinger, 2003; Kemp, 1996). These differences in age and sexual orientation also lead to cultural clashes between the residents and PSWs and among the residents due to the difficulty residents face in forming relationships and friendships based on these cultural differences. Although the majority age demographic among the LTC home residents are older adults (Berta et al., 2005; Cloutier-Fisher & Joseph, 2000), and the percentage of LTC residents in Ontario under the age of 65 is 3% (CBOC, 2011), the PSW participants' stories in this LTC home underscored that the cultural minorities in the LTC home (younger residents and transgender residents) should not be neglected in the provision of culturally competent and person centered care. The PSW participants' perceived that culturally competent care is delivered by recognizing the broad components of the residents' identities. This recognition may be partly because residents of this home are relatively homogenous in terms of ethno-cultural diversity. Since diversity is taking on a different meaning in each LTC home setting, it is important to understand cultural competence in a broader organizational context.

Description of Attributes of Cultural Competence among PSWs

In this section, the researcher will compare the three attributes of cultural competence (the middle column found in both models) between the PSW model and Suh's model (2004). Suh (2004) noted that "openness", "ability", and "flexibility" are three factors that encourage individual nurses to practice cultural competence. The findings of this study suggest that these attributes are closely related to and influenced by the following factors: the LTC home's policies, the availability of resources, in-services and education opportunities, and the PSWs' work conditions. Table 8. provides specific details on the comparisons of the content between Suh's (2004) model and the PSW model s of cultural competence with respect to these three attributes.

Table 8. Comparison of Attributes of Cultural Competence (CC)

	Suh's (2004) Model	LTC Home Model	Meanings of CC Perceived by PSWs
Openness	Being open minded Acceptance and Respect	"Here for the Residents"* Delegation of Tasks between PSWs* "Participate in the Life of the LTC Home" and Make Decisions*	Openness at this LTC home is practiced through the PSWs' mindset of being "here for the residents."PSWs are open to delegate tasks with each other by switching the role to provide care depending on the resident's comfort level if it is necessary. This openness allows PSWs to be involved in decision making, and exercise their autonomy. Overall, these characteristics of openness makes PSWs feel that they are part of the organization and motivates them to "participate in the life of the LTC home."
Ability	Solving Cultural Disparities between Patients and Healthcare Providers	Multi-cultural Staff* Collaborative Problem Solving*	"Cultural disparities" are resolved through the LTC home's resources of multi-cultural staff and the collaborative approach. In addition, PSWs are offered in-services that teach them how to complete tasks in a compassionate and empathetic manner, skills that are useful toward the delivery of cultural competence. Although the PSW participants discuss their knowledge of these in-services, their task oriented work conditions suggest that they may not have enough time to take full advantage of these skills.
Flexibility	Adapting to Different Situations Appreciation of Other Cultures	Adapting to Residents' Schedule* Team Approach to Care*	PSWs are encouraged to be flexible in their tasks in order to accommodate to residents' schedule and needs (such as allowing them to pray during a communal meal time, or letting them to watch a television show after the scheduled bedtime). PSWs are required to be flexible in their work routine in order to work collaboratively as a team with other PSWs and other staff departments.

*Collective practice of cultural competence

As indicated in Table 8., the major difference is that the PSWs in this study perceive "ability", "flexibility", and "openness" as a collective experience rather than an individual experience found in Suh's (2004) model. The reason for this difference may be due to the "collaborative team approach" that the PSWs are encouraged to practice in this LTC home.

In summary, the findings of this study suggest that the three attributes of cultural competence in PSW model can be used as guidelines for organizations to create supportive work conditions and an organizational culture that encourage PSWs to practice cultural competence. The PSW model of cultural competence from this study presents the collective work conditions that enhance culturally competent care. Furthermore, the findings of the present study also revealed the reality of PSWs' hectic work conditions that limit their development of cultural competence.

Description of Outcomes of Cultural Competence among PSWs

The outcomes of cultural competence, which appear in the right side of both cultural competence models, displays outcomes of cultural competence at the receiver, provider, and organizational levels. Table 9. presents the comparison of these outcomes between the PSW model and Suh's (2004) model.

Table 9. Comparison of Outcomes of Cultural Competence (CC)

	Suh's (2004) Model	**LTC Home Model**	**Meanings of CC Perceived by PSWs**
Provider Based Outcomes	Personal & Professional Growth Cognitive Growth	In-Service Education Fuels Passion for Work Leadership Approach to Care Supportive Environment	PSWs gain passion for their work through attending in-services because they feel that ongoing education updates their skills to meet the residents' evolving needs. The hiring managers aim to hire PSWs who express this desire to learn more in order to maintain the morale of the home. PSWs are able use their leadership skills in their daily practice. Culturally competent care helps to build better relationships between PSWs and residents, creating a supportive work environment for the PSWs.
Receiver Based Outcomes	Holistic Nursing Care Increased Quality of Life Increased Healthcare Satisfaction Adherence to Treatment	Maintain cultural practices Creation of Homelike Environment "Destination of Choice"	In the process of receiving culturally competent care, residents have the opportunity to maintain their cultural practices. By maintaining these cultural practices, the residents can continue living their life with dignity in a homelike environment. This characteristic of the LTC home helps residents and their family members decide that the LTC home is the residents' "destination of choice."
Organizational Outcomes	Increased Quality of Nursing Performance Treatment Effectiveness Cost Effectiveness	Equal Inclusion of Residents and Staff "Excellence in Care"	A culturally competent LTC home environment is one in which residents and staff are equally valued The organizational goal "excellence in care" (such as continuous research and education) is akin to increasing cultural competence among its staff members. Enhancing "excellence in care" not only creates a supportive LTC home environment but also leads to "treatment effectiveness" as well as "cost effectiveness."

As summarized in Table 9., differences between the two models are based on the differing nature of care between acute care settings and LTC home settings, and the differences in how these goals are viewed and affect the overall process of cultural competence.

The difference in "receiver based outcomes" lies in the fact that LTC home delivery is characterized by the integration of the medical model and social model of care, placing more focus on the social model of care (CHA, 2005; CBOC, 2011; Daly, 2007; Gibson & Barsade, 2003; Robinson & Gallagher, 2008; MOHLTC, 2011). The PSW participants in the present research study expressed that their main concern is to ensure that residents are comfortable in their home environment. Not only is this focus of care consistent with an emphasis on preserving the residents' dignity, independence, privacy, and respect in the Residents Bill of Rights (LTC Homes Act, 2007), but it is also consistent with examples found in literature on the importance of preserving culture at the end of life while still maintaining the residents' overall condition. The residents in the LTC home are permitted to continue their cultural practices if their health is not affected by the continuation of these practices. This type of negotiation with the residents' continuation of their cultural practices in relation to their health overlaps with previous literature on Muslim residents to continue religious practices of fasting if it does not interfere with medication intake (Kemp, 1996) and Chinese residents continuation of practices of Traditional Chinese Medicine if it does not harm their health (Chan & Kayser-Jones, 2005).While "adherence to treatment" (Suh, 2004) is still important at the end of life, these aforementioned studies and the findings from this case study display the

balance between preserving cultural practices in a manner that remains beneficial to the residents' health.

The findings of this case study also suggested a different meaning to "receiver based outcomes" of "quality of life" and "holistic nursing care" found in Suh's (2004) model because of the differing nature of care. A major focus of LTC is to alleviate physical and emotional symptoms (Robinson & Gallagher, 2008). In a LTC home, health is "not merely the absence of disease or injury" (WHO, 1948). LTC home staff are aware that the focus of LTC delivery is not on curative care (CIHI, 2006). The findings of the present study contribute to the previously mentioned literature by discovering that the residents' lives are "recognize[d] and celebrate[d]" (Philosophy of Care). Another major difference in "receiver based outcomes" between Suh's (2004) model and the PSW model of cultural competence is that a LTC home aims to be a "destination of choice." The concept of "choosing" to live in a specific LTC home distinguishes the study's model from Suh's (2004) model and is also consistent with Canadian Healthcare Association's (2009) viewpoint that a LTC home should be a chosen place where someone ages with dignity and respect. While both acute care settings and LTC homes share a similar goal in terms of providing high quality care, there is a competitive market between LTC homes that compel administrators to occupy spaces and make it a "destination of choice." Culturally competent care can enhance the quality of the "destination of choice" through the provision of individualized care.

Akin to Suh (2004) and other major theorists' acknowledgement that becoming culturally competent is a process (Burchum, 2002; Campinha-Bacote, 1999; Cross, Bazron & Dennis, 1989; Orque, 1983; Pacquaio, 2003; Papadopoulous & Lees, 2002;

Shen, 2004), the findings of this research study have also indicated a process-oriented model. However, a close examination of this pattern suggests that the process is different between acute care settings and a LTC home setting. At the LTC home, goals or outcomes are not the end result for achieving cultural competence. Instead, these goals or outcomes are used as another level of thresholds at which the organization and PSWs will continue to optimize the quality of culturally competent care and the supportive environment. The process of cultural competence in Suh's (2004) model appears to be in a linear fashion as if the process ends once the outcomes have been achieved. However, the PSW participants' responses indicated that their perceptions of cultural competence are cultivated and developed through ongoing daily practice and close interaction with residents who have evolving needs during their long stay at the home. Thus, culturally competent practice evolves as the residents' need evolve.

In summary, through the comparison of Suh's model (2004) and the PSW model , the researcher was led to find that cultural competence in the LTC home context is different from the recommended mode of practice in acute care settings. The next section will provide more details on how cultural competence adds to the characteristics of person centered care.

The Link between Culturally Competent Care and Person Centered Care in the LTC home

PSWs participants in this case study were unfamiliar with the phrase "cultural competence" albeit the Ministry of Training, Colleges, and Universities' (2004) requirement for PSWs in Ontario to provide culturally sensitive care. However, PSW participants' accounts revealed that their perceptions and definitions of culture and

culturally competent care are closely connected to the main features and goals of person centered care.

A closer examination of the contents of the attributes in the PSW model of cultural competence implies the connection between cultural competence and person centered care. The PSWs' open attitude of being "here for the residents" embodies the essence of person centered care. The PSW participants demonstrated their "openness" by expressing their awareness of the importance of reserving their own biases in order to meet the residents' needs. The collaborative nature of problem solving, the practice of "ability", also places PSWs in a position to be part of the decision making process, an integral component of person centered care (Gnaedinger, 2003; Janes, 2008). Person centered care at LTC homes involves personal assessments to create daily schedules for residents (Crandall et al, 2007; Jones, 2011; Kitwood,1997;Kontos et al., 2010;Robinson & Gallagher, 2008;), which in turn allows the care providers to value the residents' individual needs. These assessments are intended to eliminate the task-oriented nature of care and allow more flexibility in the PSWs work routine and the residents' daily routine. The more knowledge that PSWs have about residents' unique needs, the more they can adapt their tasks to those preferences. Flexibility in the residents own schedule is encouraged within the practice of person centered care (Gnaedinger, 2003; MOHLTC, 2008). The DOC mentioned that "limited resources" at the home ironically created opportunities for overlap to occur between staff departments and extend a team approach to care, leading them to enhance their "flexibility" (Suh, 2004). More specifically, if a staff member from one department needed assistance with completing a task, and staff

from that same department are unavailable, staff members from another department are likely to provide that type of assistance if they are qualified to do so.

The marked difference in the process of health care providers becoming culturally competent in Suh's (2004) model and the PSW model of cultural competence, stemming from the differing nature of the two health care settings, draw a connection between cultural competence and person centered care. Since LTC homes have been traditionally operated with a focus on the medical model (Jones, 2011; Gibson & Barsade, 2003; Robinson & Gallagher, 2008), it will take time before person centered care is fully implemented at LTC homes (CBOC, 2011; CHA, 2009; Crandall, et al., 2007; Jones, 2011; Nayak, 2007; Rahman & Schnelle, 2008). Parker and Geron (2008) stated that cultural competence has recently been introduced to LTC home research. However, the transition to change the nature of LTC delivery is still in progress (Parker &Geron, 2008; Rahman & Schnelle, 2008). The PSW model generated from the findings of this case study can illustrate an example of how the process of cultural competence in a LTC home setting takes shape. This qualitative case study yielded findings of the factors that enhance and hinder the process of cultural competence. Through recognition of the role that culture plays in providing individualized person centered care, the researcher also identified how the practice of culturally competent LTC delivery contributes to the home's ongoing transition toward person centered care.

According to the DOC's and PSW participants' reflections, culture plays a role in the residents' rights to maintain their autonomy and make choices. Person centered care advocates for preserving residents' autonomy and their ability to make choices (Crandall et al., 2007; Kitwood, 1997; Janes, 2008; Jones, 2011; Robinson & Gallagher, 2008). The

findings of the present study suggest that the first step toward achieving these outcomes is through the accumulation of information on the residents by assessing the residents' daily needs (Crandall et al., 2007; Kontos et al., 2010; Robinson & Gallagher, 2008). However, the findings of the present study have shown that PSWs do not always have access to the information on the initial assessments that are conducted when a resident moves to the LTC home. Also, PSW participants stated that they do not have the opportunities to access this information due to the lack of time to collaborate with the Social Worker. Therefore, they do not always know the residents unique needs. Nevertheless, the PSW participants described their efforts to collect residents' personal needs in their daily interactions without the official information from the assessments. This finding overlaps with Kontos et al.'s (2010) findings that PSWs are resourceful staff members who can help to fill in the existing gaps and flaws of the standardized assessment tools commonly used in Ontario LTC homes and also adds to Janes' (2008) research on PSWs' important contributions to the decision making process.

PSWs at this home understand that the knowledge of the residents' unique needs and preferences are crucial pieces of information that facilitate their provision of culturally competent care, which is also similar to person centered care. In one sense, the approaches for developing their cultural competence used by PSWs and DOCs in this LTC home are related to the "cultural generic" approach (Shapiro et al., 2005) and "cultural general" approach (Taylor, 2005). These approaches teach the knowledge, skills, and attitudes that can be applied to any cultural groups without placing stereotypes on the residents. In fact, person centered care also acknowledges a non-stereotypical approach to each resident based on this broad nature of culture.

Staff empowerment and leadership skills are promoted in the delivery of person centered care (Janes, 2008; Jones, 2011; Robinson & Gallagher, 2008). The findings of the present study revealed that leadership skills and empowerment has been recognized as important aspects of culturally competent care. Barry et al. (2005) explored the effect of encouraging PSWs to use empowerment techniques on the quality of care in LTC homes in the United States and found that the outcomes were positive. In the present study, PSWs felt valued for their contributions to the decision making process and their ability to build a relationship with the residents. This finding contributes to previous research on LTC home staff empowerment and decision making power (Janes, 2008; McAiney, 1997).

While the connection between cultural competence and person centered care was shown in the previous section, the present study's findings also suggest some parallels between the goals of person centered care. In addition, culturally competent approaches, such as the "cultural generic" approach (Shapiro et al., 2005) and the "cultural general" approach (Taylor, 2005), add further depth to the concept of person centered care, thereby enhancing the quality of person centered care.

PSWs' Work Conditions

The findings from this study contributed to literature on the PSWs' work conditions by indicating how these work conditions affect their capacity to provide culturally competent care. PSWs' culturally competent work conditions stemmed from the home's "meticulous hiring process" and the collaborative work environment.

The impact of staff selection on the PSWs' capacity to provide culturally competent care was described in the present research study. In Stolee et al.'s (2005) study

on effectiveness of integrating continuing education into everyday practice, they found that PSW staff in Ontario are under qualified as a consequence of minimal practical training. The findings of the present case study contrasted this finding. Since the LTC home staff place high standards for PSWs, they feel it is best to hire the people who graduated from a specific college which offers 18 months of experience in practical training. According to Gnaedinger (2003), the use of generic job descriptions and benchmarks when hiring PSWs can be problematic to the quality of care delivered because it leads to hiring unqualified staff. Contrary to this viewpoint, the findings of the present study suggest that benchmarks or standards are helpful guidelines that allow hiring managers to be mindful of the important factors that need to be considered when hiring PSWs. The findings of the present study suggest that qualified PSWs demonstrate: an understanding of the home's philosophy, an understanding and appreciation for cultural diversity, and a dedicated commitment toward working at the LTC home.

It is also notable that this LTC home allows the PSWs have the freedom to change their employment position internally. In this process, the LTC home staff makes seniority a priority in hiring by placing emphasis on seniority as a part of suitability. On the other hand, Gnaedinger (2003) expresses that hiring upon the basis of seniority is not connected to suitability. The findings from the present study suggest that the proactive and flexible approach with careful hiring and internal mobility at the LTC home contributes to the PSWs job satisfaction and long duration of employment.

The findings of this case study provided a thorough description of the collaborative work environment and its contribution to culturally competent care. Barry et al. (2005) stated that the environment of the LTC home is indicative of PSWs' ability

to execute their decision making power. Parker and Geron (2007) found that collaboration enhances culturally competent care. The findings of this case study suggested that both collaboration and decision making are intertwined concepts. In this study, the PSWs participants collaborate with each other and other staff departments to solve problems. If they are unsure of how to resolve a difficult situation they face with a resident, they seek advice from their fellow PSWs on how to handle the situation. This type of collaboration helps PSWs learn more about the residents' unique cultural background. Previous studies found that PSWs are commonly from ethnically diverse backgrounds (Lilly 2008; Geron & Parker, 2007).The PSWs in the present study were also from various ethno-cultural backgrounds. However, unlike Geron & Parker's (2007) study, the PSWs in this LTC home did not find their language and cultural differences as major obstacles for their communication with residences as well as other staff members. Although PSW participants referred to occurrences when discriminatory comments were made by the residents toward some non Caucasian PSWs, these cultural clashes were often solved among PSWs by exchanging information or switching their roles. The findings of the present study contribute further information on the manner in which PSWs from ethnically diverse backgrounds are a beneficial resource for enhancing collaborative work conditions and in turn culturally competent care.

Despite the supportive environment that encourages leadership approaches to care, the findings from the present study reveal that PSWs face some barriers toward providing culturally competent care. First, while the LTC home staff encourages PSWs to attend in-services, in reality, PSWs' hectic work schedule and the lack of additional PSW staff make it difficult for them to take advantage of these opportunities for their

professional development. The findings of this case study overlap with Gnaedinger's (2003) finding that identified the high use of casual staff as a negative work condition in LTC homes. "Not knowing the floor", as expressed by the PSW participants, was a major issue that impacted the casual PSW staff's opportunities to build relationships with the residents and learn their diverse needs, leading to inconsistencies in the quality of person centered care (Gnaedinger, 2003). In addition, the impact of PSWs' absence from care conferences to provide their input on care plans was also highlighted (Kontos et al., 2010). The researcher learned that the PSW participants' unique experiences with the residents would have been an exceptional contribution to the quality of information on each resident's care plan.

Limitations and Strengths of the Study

This study has a couple of limitations. First, despite her persistent efforts, the researcher was unable to recruit 10-12 PSWs for focus groups due to their busy work conditions. Although the researcher managed to cover all topics that she had planned to ask by eliminating repetitive questions, the length of each focus group sessions was also to be reduced due to PSWs work schedule.

The second limitation of this study is that the PSW participants all worked in the same home unit. Although some PSWs participants provided their insights from their experiences with working on other home units, the quality of the data would have been enriched by hearing the voices of PSWs working in more diverse units where they may have had different experiences. The findings of the study would have been strengthened if part-time and casual PSWs also participated in the study. Their contributions to the

study would add further depth and insight on the various types of experiences that both part-time and full-time staff have in conjunction with cultural competence.

Despite these limitations, there are also some strengths present in this study. The triangulation of data with three data sources complement and validate the findings from each data source. Parker and Geron (2007) noted that solely investigating the policies for evidence of cultural competence practice in the LTC home setting does not provide solid evidence on the practice of cultural competence. The step by step data collection and constant comparative analysis techniques that were incorporated into the present study helped the researcher learn how policies are implemented and how they influence the DOC's and PSWs' perceptions of cultural competence. Using the qualitative case study method for assessing cultural competence in a LTC home allowed the researcher to listen to PSWs' opinions that tend to be unheard in existing LTC home literature. In addition, the qualitative case study method helped the researcher to collect detailed and rich contextual data. Thus, the researcher found not only the components, process, and outcomes of cultural competence perceived by PSWs, but also the organizational environmental factors that could enhance and hinder the PSWs' culturally competent practice in the LTC home.

Implications for Future Research

The findings of this research study raised the following questions for future research:

- How do nurses and other LTC home staff perceive cultural competence? Based on their work role, what are the similarities and differences between their perceptions and the PSWs perceptions?

- What are the conditions of cultural competence in other Ontario LTC homes? Is the perception of cultural competence also connected to person centered care in these homes?
- What is the specific conceptual link between cultural competence and person centered care? Are they related concepts and in what way are they related?

Since PSWs are an understudied group, it is essential to continue further research and gather more information on their work conditions and their experiences. Although the PSW participants from this study were generous in sharing knowledge and expertise on the LTC home, there remains a need to hear the voices of the part-time, casual, and part-time casual staff. These staff members' contributions to the research on cultural competence in LTC homes would aid administrators to address the areas that need to be improved so that staff from all positions can equally deliver culturally competent care. In the LTC home from the present study, this holds especially true since the DOC noted that there is a high number of casual staff and the high reliance on them in a large home such as this one poses is problematic. Also, if there are different home units within a LTC home, it would be more efficient to recruit PSWs from each home unit so that there is potentially more variety in responses and stronger validity of findings.

In addition, this case study brought the ambiguous context of cultural competence and its close link to person centered care in the LTC setting to the forefront. Thus, it is worth further exploration on this topic in different LTC homes in Ontario. As previously mentioned, the qualitative case study approach has shown to be effective in exploring this relatively unknown topic. Nevertheless, in order to assess and gain an overview of conditions of cultural competence across Ontario LTC homes in the future, it would be

beneficial to conduct a quantitative survey as a part of a broader MOHLTC's assessment of LTC homes.

Implications for Practice

Through the DOC's and PSW participants' suggestions for enhancing the culturally competent LTC, a number of implications for practice have been brought to the forefront. The study implied the ambiguous understanding of "cultural competence" among the PSWs. Furthermore, the findings also suggested the close relationship between "culturally competent care" and "person centered care" and the strong influence of work environment on PSWs practice on culturally competent care.
Therefore, there is a need to raise awareness on cultural competence in LTC home settings and improve the PSWs' work conditions in a manner that encourages the practice of culturally competent care.

In order to raise more awareness on cultural competence in the LTC home, the organization can take both the "cultural generic" (Shapiro et al., 2005) and "culture general" (Taylor, 2005) approach, and update knowledge about "cultural competence" among the PSWs. They can integrate this new concept into existing person centered care training and practice in the LTC home. In effect, culturally competent practice will help PSWs broaden their perspectives on various aspects of cultural and personal preferences and needs by adding another layer to the concept of the holistic approach to care. A balanced ratio of staff to residents would be ideal since it will allow PSWs to learn about the residents' unique needs, and in effect meet these needs. Increasing the number of PSW staff may also strengthen the quality of the "supportive environment" for both the PSWs and the residents. PSWs may not feel rushed while completing tasks and they can

spend more time with residents and family members to get to know them better. Increased PSW positions will also promote further opportunities to be flexible and attend in-services, utilize the skills learned from these in-services, and participate in research. However, in reality, it may not be feasible to increase the staffing levels in the near future. If increasing funding for hiring more full-time PSWs is not possible at the present time, it may be beneficial for the LTC home staff to improve the strengths of the home by taking full advantage of home's existing resources including in-service trainings and the supportive team work environment. While the available in-services have been noted as beneficial, some PSW participants noted that difficulties in taking full advantage of these sessions due to lack of time to attend the sessions or lack of time to utilize their new skills. This gap between the organizational policies and the reality of the PSWs' work conditions should be clearly recognized by the LTC home administrators so that they could find ways to make these in-services more accommodating to the PSWs' schedules. In turn, these improvements will also enhance the supportive team work environment.

Since this LTC home takes pride in "excellence in care through research and education" (Value statement), it appears that the LTC home staff provides various opportunities for in-services as a way to update the PSWs skills and knowledge. The LTC home should not only recommend PSWs to attend in-services, but also secure time for PSWs to make full use of these in-services as opportunities to enhance their professional development. The DOC and PSWs suggested ideas on in-services for teaching cultural competence in a manner that can be integrated into their everyday practice. Their suggestions about the contents of the in-services include teaching empathy and creating cultural "theme days" that teach PSWs about the residents' diverse cultures. Training

sessions should also be convenient for the PSWs' time schedule so that they are able and willing to attend and learn. Also, the opportunity to utilize the new skills that are taught in the in-services needs to be available for the PSWs. Since the DOC and PSW participants agreed that "hands on training" is an effective teaching method at in-services, further incorporation of this method may help PSWs to utilize their new skills. Perhaps in-services related to PSWs' practical training can be taught while PSWs are providing care to residents who require less assistance with their activities of daily living. For example, since the PSW participants in this study mentioned that meal times and bath times were prime opportunities to learn about the residents' needs, further encouragement to use these opportunities for in-service training of culturally competent practice could be beneficial. Perhaps the PSWs who have experience in using this method and other successful methods of providing culturally competent care could mentor the part-time and new PSWs staff in successfully delivering care. This incorporation of the hands-on culturally competent training may help PSWs to understand and grasp the feasibility of incorporating their new skills into practice so that they can continue to use these skills with all residents. In addition, skills should be taught in an applicable manner that best suits the fast paced nature of the day shift so that the inconsistency in the quality of care is alleviated between the quality of care provided in the day shift and the night shift.

Further collaboration between PSWs and other staff departments is helpful to enhance culturally competent care at an organizational level. For example, allotting the time for communication between the Social Workers and PSWs on information regarding individual residents will help PSWs to appropriately accommodate their care delivery to each resident's unique needs. Dietary staff should also be provided with adequate

information about residents' diverse dietary preferences. In addition, through their direct interactions with residents on a daily basis, PSWs learn a great body of knowledge about each resident's cultural needs. Therefore, they would be able to make valuable collaborative contributions to develop residents 'care plans if their opinions are more appreciated.

Reflection and Conclusive Remarks

Overall, the results of the study provide additional knowledge to the literature, while underscoring the necessity for further research and improvement in practice regarding cultural competence and work conditions among PSWs in LTC home settings in Ontario. The differences in cultural competence in a LTC home setting among PSWs in comparison to cultural competence in an acute care setting were highlighted. The findings of this research study also served as the first step toward further examinations of connections between concepts of cultural competence and person centered care. The investigation of PSWs' perceptions and practice of culturally competent care within the context of their work conditions helped the researcher understand the current status of cultural competence in the LTC home setting; information that has remained somewhat invisible in research. Although the terminology is not explicitly used in research, the findings from the present study demonstrate that culturally competent care has been actually practiced as a part of person centered care, and it benefits PSWs, residents, and the LTC home. This unexpected, but interesting, finding of this study provides a foundation and rationale for further promotion of cultural competence in the LTC home settings.

The researcher felt the need to conduct this study for two reasons: to fill the knowledge gap on cultural competence in LTC homes from the perspectives of PSWs, and to assess cultural competence using a qualitative approach. Although PSWs are an increasing workforce in LTC provision, their status as unregulated healthcare workers and their role in the social model of care has marginalized them in the healthcare system, thereby leaving their voices unheard in research and practice. Using the qualitative case study approach helped the researcher not only assess cultural competence among PSWs, but also understand how the concept is shaped within the unique context of their working conditions within a specific LTC home. Additionally, the unexpectedly difficult recruitment process provided the researcher with a good opportunity to witness the PSWs' hectic work conditions.

Through conducting this qualitative study, the researcher further understood the merit in thoroughly planning a research study in advance to maintain its rigor. At the same time, however, she also learned that it is important to be patient and flexible in the research process. In a qualitative study, regardless of how thorough the study is planned ahead of time, certain elements of the study do not run according to plan. This qualitative case study was no exception. Whenever the researcher faced any unforeseen challenges in the study, she needed to be calm, persistent, and open minded to make any necessary changes to her original plan. The researcher also learned the value of incorporating triangulation of the data sources as a means of gaining a thorough understanding of the study's topic. The discrepancies of information found in each data source often helped the researcher to progress in her analysis and add richness to the study's findings.

In retrospect, had the researcher been afforded the opportunity to repeat this study, certain parts of the study would have been conducted differently. Recruitment would have been planned in a manner that best suited the dynamics of the LTC home. Based on the researcher's experience in recruiting PSWs for this study, she surmised that the short staffing and the hectic work conditions in LTC homes may attribute to the lack of research on PSWs. Instead of aiming to recruit 10-12 PSWs from the entire home, it may have been beneficial to devise a recruitment strategy that was narrowed down to more specific attributes of the home. For example, since this was a large LTC home with 15 home units, it may have been beneficial to plan her initial recruitment strategy with the aim to recruit at least 1 PSW from each home unit. In addition, the lack of an honorarium for focus group participants may have been an issue that affected the recruitment. Monetary incentives to reward participation may have encouraged the PSWs to participate in a focus group session, especially since their work conditions were so hectic and some of the participants obtained part-time employment outside the home.

Given the nature of LTC delivery, with its increasing emphasis on the integration of the social model of care, there is a need to raise awareness about the importance of cultural competence in LTC homes. In particular, if PSWs, whose work involves providing constant care to support residents' activities of daily living, are not familiar with the concept of cultural competence, it is crucial to include this concept into their professional training. Fortunately, like the PSW participants in this study, many PSWs who work in LTC homes are likely to be familiar with the concept of person centered care. Therefore, if cultural competence and cultural sensitivity were introduced in tandem with person centered care, it would be easier for PSWs and other LTC staff to adopt the

idea. The promotion of culturally competent care will also be beneficial for the future challenges facing LTC homes, such as the aging of the baby boomers, the increase of ethnically and linguistically diverse older adults (CBOC, 2011), and the increase of younger adults in need of LTC services and transgendered residents. The findings from this case study elicit the need to broaden the concept of "cultural competence", especially in LTC home settings where care providers need to be sensitive to various personal needs and lifestyle preferences that are beyond narrowly defined stereotypical ethno-cultural differences. It is the researcher's sincere hope that this research study will encourage further research on cultural competence and PSWs' working conditions in LTC homes in Ontario and other provinces in order to improve the quality of care and support that residents receive in their final home.

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APPENDIX A: Case Recruitment Flyer

Exploring the Perceptions of Personal Support Workers on Cultural Competence in an Ontario LTC Home: A Case Study

Aysha Tayab, M.A. Candidate, Brock University

Background:

Although Canada is a country rich in its cultural diversity, considerations of a patent's culture have been neglected in long-term care practice. As a result, the focus has been centered on the patient's ailment or physical condition. As of 2001, there have been approximately 240,000 newcomers arriving into Canada each year (Statistics Canada, 2009). In order to accommodate to diverse patient population, cultural competence can serve as an aide in
eliminating misunderstandings that may arise. Cultural competence is defined by the implementation of behaviors, attitudes and policies that enable staff and the organization to work effectively in cross cultural situations. However, there is a scarce amount of literature and research on cultural competence in Canadian long term care. Based on this information, the purpose of this research study is to bridge this gap in knowledge by answering the following questions:

1. What organizational policies and resources are present for enhancing culturally competent care?
2. How do staff and the DOC of a long term care organization perceive the meaning of cultural competence?
3. What are the perceived challenges and possibilities do the DOC and LTC staff in promoting cultural competence in the organization?
4. What potential resources are needed to implement culturally competent care in a LTC organization?

The Role of the Long Term Care Home:

Your participation in this study is greatly appreciated. During the focus group session, I will be providing light refreshments. All information will be kept confidential. You are permitted to withdraw at anytime if you feel the need to do so.

Your involvement in this study will not intrude upon the work conditions in the LTC home. I would like to conduct the data collection phases in a manner that will make this possible.

Proposed Methods:

I will collect information on a long term care home through the exploration of perceptions of cultural competence.

Data will be collected using the following process:

- Policy → Document Analysis
- DOC/ Executive Director → Key Informant Interview
- PSW's → Focus Group

I will conduct a document analysis of the home's mission statement and resident's rights, a key informant interview with the DOC or executive director, and a focus group with 10-12 PSW's in order to learn more information about the long term care home. The Executive Director and PSW's are invited to participate in this study.

Importance and Benefits of Research Study:

Among the older adult population, there is a growing need for long term care services. Furthermore, there is an increasing demand and utilization for long term care services among older adults from diverse ethnic and cultural backgrounds. The healthy immigrant effect may lead to deterioration in health, thereby increasing the demand for long term care. Culturally competent long term care will accommodate to the older adult's needs.

Due to the unique nature of each long term care home, it is essential to explore the staff's perceptions of cultural competence within the context of a specific home. Furthermore, the case study approach will serve as an example to account for the state of cultural competence within the context of Canadian long term care.

By the end of the data collection phases, I hope to provide a greater awareness among the staff on the importance of cultural competence in the delivery of long term care. Also, I hope that this study will encourage further organizational development with consideration toward cultural competence practice and training.

This study has received ethics clearance through Brock University's Research Ethics Board (FILE # 09-211) . If you are interested in participating, please do not hesitate to contact me by phone (905) 688- 5550 ext. 3882 or e-mail at08ke@brocku.ca. You may also contact the supervisor of this project Dr. Miya Narushima by phone (905) 688-5550 ext. 5149.

APPENDIX B: Letter of Reference To LTC Facilities

February 15, 2010

To whom it may concern;

My name is Miya Narushima, and I am an assistant professor who teaches gerontology in the Department of Community Health Sciences at Brock University. My graduate student, Aysha Tayab, who plans to work in the long term care and gerontology field in the future, is planning to do a case study of "perceptions of cultural competence" in a long-term health care organization for her MA thesis. Although St. Catharines has increasing number of immigrants and refugees, we have been unable to find long term care homes with much ethno-cultural diversity in the Niagara Region. Therefore, we have decided to expand our case-selection target area to the Hamilton Area.

I called the CCAC Human Resources and Information Referral Team and asked the Director Ms Susan Gibson, for her suggestions on this matter. She kindly suggested that we should contact each long term care facility directly, asking for its organizational collaboration to our case study. Therefore, Aysha is now visiting you to distribute a flyer and explain the purpose of her study. Aysha is a responsible, mature, and hard-working student. Prior to the commencement of her study, she will obtain an Ethics Clearance from Brock University Research Ethics Board (and from your organization's ethics board if necessary). Her study will be conducted under the careful supervision of myself and two other faculty members of Brock University. If your organization could kindly consider to participate in this study as a "case" organization to help her study, I would be most grateful. Please feel free to contact me should you have further questions.

Thank you very much for your time and consideration.

Yours sincerely,

Miya Narushima

Assistant Professor
Community Health Sciences, Brock University
St. Catharines, ON. L2S 3A1
Phone: 905 688-5550, x5149,
Email: mnarushima@brocku.ca

APPENDIX C: Letter of Invitation For Key Informant Interview

Title of Study: Exploring the Perceptions of Personal Support Workers on Cultural Competence in an Ontario LTC Home: A Case Study
Principal Student Investigator**:** Aysha Tayab, M.A. Candidate, Department of Community Health Sciences, Brock University
Faculty Supervisor:Miya Narushima, Assistant Professor, Department of Community Health Sciences, Brock University

I, Aysha Tayab, M.A. Candidate, from the Department of Community Health Sciences, Brock University, invite you to participate in a research project entitled Cultural Competence and Its Important Role In Promoting Positive Change in the Delivery of long term care: A Case Study. The purpose of this research project is to explore the perceptions of cultural competence among long term care staff within a selected long term care home. I would like to conduct an interview with the DOC or Executive Director and discuss perceptions of long term care as well as any experiences related to cultural competence. The expected duration your participation will take approximately 90-120 minutes of your time. All responses will be audio recorded. This information will only be accessed by myself and my research supervisor Dr. Miya Narushima.

This research should benefit by promoting a greater awareness of cultural competence among long term care staff. In addition, this study is intended to encourage further organizational development with consideration toward cultural competence practice and training. There are no anticipated risks to this study. All information will be strictly confidential. You may withdraw from the study at any time. This research study is a single site project. If you have any pertinent questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905 688-5550 ext 3035, reb@brocku.ca)

If you have any questions, please feel free to contact me. (905- 994-3048, at08ke@brocku.ca)
Thank you

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board (file 09-211)

APPENDIX D: Letter of Invitation for Focus Groups

Title of Study: Exploring the Perceptions of Personal Support Workers on Cultural Competence in an Ontario LTC Home: A Case Study

Principal Student Investigator: Aysha Tayab, M.A. Candidate, Department of Community Health Sciences, Brock University
Faculty Supervisor: Miya Narushima, Assistant Professor, Department of Community Health Sciences, Brock University

I, Aysha Tayab, M.A. Candidate, from the Department of Community Health Sciences, Brock University, invite you to participate in a research project entitled Exploring the Perceptions of Personal Support Workers on Cultural Competence in an Ontario Long Term Care Home: A Case Study. The purpose of this research project is to explore the perceptions of cultural competence among long term care staff within a selected long term care home. I would like to conduct a focus group with approximately 10-12 Personal Support Workers and discuss your perceptions of long term care as well as any experiences related to cultural competence. The expected duration your participation will take approximately 90-120 minutes of your time. All responses will be audio recorded and themes will be written down on a whiteboard in front of all participants. This information will only be accessed by myself and my research supervisor Dr. Miya Narushima.

This research should benefit by promoting a greater awareness of cultural competence among long term care staff. In addition, this study is intended to encourage further organizational development with consideration toward cultural competence practice and training. There are no anticipated risks to this study. All information will be strictly confidential. You may withdraw from the study at any time. However, there are no guarantees that your responses from the focus group will be discarded once you have withdrawn due to the difficult nature of removing data from a focus group. This research study is a single site project. If you have any pertinent questions about your rights as a research participant, please contact the Brock University Research Ethics Officer (905 688-5550 ext 3035, reb@brocku.ca)

If you have any questions, please feel free to contact me (**905- 688- 5550 ext. 3882**, at08ke@brocku.ca)
Thank you

This study has been reviewed and received ethics clearance through Brock University's Research Ethics Board (file 09-211)

APPENDIX E: Consent Form for Key Informant Interview

Date: **April 20, 2010**

Project Title: **Exploring the Perceptions of Personal Support Workers on Cultural Competence in an Ontario LTC Home: A Case Study**

Principal Student Investigator:
Aysha Tayab, M.A. Candidate
Department of Community Health Sciences
Brock University
(905) 688-5550 Ext. 3882
at08ke@brocku.ca

Faculty Supervisor:
Dr. Miya Narushima, Research Supervisor
Department of Community Health Sciences
Brock University
(905) 688-5550 Ext. 5149
mnarushima@brocku.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to utilize the case study approach in order to explore the perceptions of cultural competence among PSW staff.

WHAT'S INVOLVED

As a participant, you will be asked to answer the questions that the researcher asks of you in the interview Participation in the interview will take approximately 90-120 minutes of your time.

POTENTIAL BENEFITS AND RISKS

Possible benefits of participation include greater awareness of cultural competence among PSW staff. In addition, this study is intended to encourage further organizational development with consideration toward cultural competence practice and training. **You are under no obligation to participate in this voluntary study.**

CONFIDENTIALITY

The information you provide will be kept confidential. Your name will not appear in any thesis or report resulting from this study; however, with your permission, anonymous quotations may be used. Shortly after the interview has been completed, I will send you a copy of the transcript to give you an opportunity to confirm the accuracy of our conversation and to add or clarify any points that you wish.

Data collected during this study will be stored in a locked cabinet in the supervisor's office. Data will be kept until the completion of the research study after which time the data will then be disposed. Access to this data will be restricted to the student and the research supervisor.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. I will **collaborate with my faculty supervisor as in order to determine what information will be revealed in the final thesis paper. The name of the home will not be revealed in the final thesis paper unless I have your permission to do so.** Feedback about this study will be available by as soon as the study has been completed. If you wish to view the results of this study, please contact me by e-mail.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact the Principal Investigator or the Faculty Supervisor (where applicable) using the contact information provided above. This study has been reviewed and received ethics clearance through the Research Ethics Board at Brock University (insert file #). If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

APPENDIX F: Key Informant Interview Guide

I. DOC and Environmental Context of the Organization

1) To begin with, could you briefly tell me about yourself?
   Probe 1: Could you tell me about your training background?
   Probe 2:How do you direct the PSWs? Could briefly describe a typical day involving the PSWs?
   Probe 3: How long have you been working here?

2) Regarding the residents , where are they from?
   Probe 1: Are many of them from the Hamilton area?
   Probe 2: What are the cultural and ethnic backgrounds among the residents? Probe 3: What about religious backgrounds?
   Probe 4: Are there any language barriers between you and the residents?

3) How about your PSW staff, where are they from?
   Probe 1: Where are your PSW staff from? Are most of them from this region?
   Probe 2: How about their ethno-cultural and religious backgrounds? What languages do they speak?
   Probe 3: Do you face difficulties in communicating with your PSW staff based on these language and cultural differences? If so, could you describe an example?
   Probe 4: Do you see a possibility for an increased need for PSWs at St. Joseph's Villa?
   Probe 5: Over the last 5 years, what is the increase rate of PSWs at this home?
   Probe 6: How long do you usually stay at the home?

4) How do you view the environment of this LTC home in relation to culturally competent care?
   Probe 1: Does LTC home have any policies that may be related to culturally sensitive care?
   Probe 2: If yes, could you tell me what the policies say?
   Probe 3: If you do not have policies, why?

II. Perception of Culture and Cultural Competence

5) What is your view of the term "culture competence" or "cultural sensitivity?" How do you define it?

   Probe: How do you see the role that cultural competence plays in the delivery of care?

6) The concept of "culturally competent care" has been developed mainly in the nursing field over the last 30 years. From your perspective, how do you see the relevance of cultural competence to Personal Support Workers?

   Probe: How often do you hear the words "cultural competence/culturally sensitive care" in your field? In other words, how much is "cultural competence" emphasized in LTC delivery?

7) Based on your experience working as Director of Care, how much of a need is there for culturally sensitive/competent care in your organization? Why?

   Probe 1: What do you think the residents can gain from culturally sensitive care from the PSWs at this home?

   Probe 2: What do you think that PSW staff can gain from becoming culturally sensitive?

   Probe 3: What do you think are the benefits for the organization as a whole if culturally sensitive practice was integrated?

8) Research has revealed that there a number of different "cultural clashes" between residents and staff in LTC homes. These clashes can be attributed to the differences in ethno-cultural and religious background, the professional training of the staff, and the age differences between the staff and the residents. How do you see a relevance of this cultural clash in the context?

   Probe 1: If so, what sorts of challenges have you and the staff faced?

   Probe 2: How were these clashes resolved?

   Probe 3: What procedure do PSWs usually need to take when they face situations related to a cultural clash? Do they consult with you first, or need permission to change their care procedure to cope with demands from the residents?

9) What type of care does your organization expect from the PSW staff?

Probe 1: What skills are required?
Probe 2: What type of knowledge do they need to have?
Probe 5: How are they expected to interact with residents from diverse cultural, ethnic and religious backgrounds?

10) How do you see your PSW staff's level of cultural sensitivity?
Probe 1: Could you give me examples of how culturally competent care is delivered?
Probe 2: How do you see the influence of PSWs own cultural background on their care practice?
Probe 3" In what way do you feel it would be appropriate for the PSWs at this home to incorporate their own cultural values into their work role? In what way should these cultural values be set aside?

11) In the past two years, have the PSW staff been provided with any in-service training on cultural sensitivity? What about the past year?
Probe 1: If yes, what was the contents of the in-service? Did you notice any changes in the staff's performance in their relationship with the residents? How?
Probe 2: If not, could you please tell me why?

15) In your view, what factors promote culturally sensitive care at this home?
Probe 1: What internal or external factors encourage culturally sensitive care at this home?

16) What factors do you think would limit this organization from integrating more culturally sensitive care?
Probe: What internal or external factors would limit culturally sensitive care at this home?

III. <u>Future Prospects</u>

17) What is your view of cultural diversity among older adults in the Hamilton region within the next few decades?

18) How you see that cultural sensitivity and person centered care as related concepts?

19) What is your opinion on the need for cultural sensitivity in the future?

20) What do you think would be the best strategy to promote cultural sensitivity among PSWs in order to enhance their care practice?

21) Do you see a possibility to develop organizational policies and training on cultural sensitivity in the future? If so, what organizational policies and training would you like to see in place? If not, why?

22) Would you like to add anything else before we finish this interview?

OK. Thank you very much for your time and valuable input.

APPENDIX G: Consent Form for Focus Groups

Date: **April 20, 2010**
Project Title: **Exploring the Perceptions of Personal Support Workers on Cultural Competence in an Ontario LTC Home: A Case Study**

Principal Student Investigator:
Aysha Tayab, M.A. Candidate
Department of Community Health Sciences
Brock University
(905) 688- 5000 ext. 3882
at08ke@brocku.ca

Faculty Supervisor:
Dr. Miya Narushima, research supervisor
Department of Community Health Sciences
Brock University
(905) 688-5550 Ext. 5149
mnarushima@brocku.ca

INVITATION

You are invited to participate in a study that involves research. The purpose of this study is to utilize the case study approach in order to explore the perceptions of cultural competence among PSW staff.

WHAT'S INVOLVED

As a participant, you will be asked to answer the questions that the researcher asks of you in the focus group. Participation in the focus group will take approximately an hour of your time. The focus group will be conducted after your shift in the meeting room. I will schedule a focus group at a time that accommodates to your schedule.

POTENTIAL BENEFITS AND RISKS

Possible benefits of participation include greater awareness of cultural competence among PSW staff. In addition, this study is intended to encourage further organizational development with consideration toward cultural competence practice and training. You are under no obligation to participate in this voluntary study**.** The principal student investigator will consult with the DOC or Executive Director on the recruitment strategy in advance in order to receive a clear confirmation that participation or non-participation in the focus group should not influence your future work conditions and relationship with your fellow employees.

CONFIDENTIALITY

All information you provide will be considered confidential and grouped with responses from other participants. Given the format of this session, we ask you to respect your fellow participants by keeping all information that identifies or could potentially identify a participant and/or his/her comments confidential

Data collected during this study will be stored in a locked cabinet in the supervisor's office. Data will be kept until the completion of the research study after which time the data will then be disposed. Access to this data will be restricted to the student and the research supervisor.

VOLUNTARY PARTICIPATION

Participation in this study is voluntary. If you wish, you may decline to answer any questions or participate in any component of the study. Further, you may decide to withdraw from this study at any time and may do so without any penalty or loss of benefits to which you are entitled. However, there are no guarantees that your responses will be discarded from the analysis due to the difficult nature of removing data once it has been collected.

PUBLICATION OF RESULTS

Results of this study may be published in professional journals and presented at conferences. Feedback about this study will be available as soon as the study has been completed. Before I begin my data analysis, I will verify the major themes with you. Once you have provided me with consent to participate in the study, please also provide your e-mail address. I will e-mail you the major themes that were gathered from this focus group session. All information will be strictly confidential It would be most appreciated if you could respond to the e-mailed results. If you wish to view the final results of this study, please contact me by e-mail.

CONTACT INFORMATION AND ETHICS CLEARANCE

If you have any questions about this study or require further information, please contact the Principal Student Investigator or the Faculty Supervisor using the contact information provided above. This study has been reviewed and received ethics clearance from the Research Ethics Board at Brock University (insert file #). If you have any comments or concerns about your rights as a research participant, please contact the Research Ethics Office at (905) 688-5550 Ext. 3035, reb@brocku.ca.

Thank you for your assistance in this project. Please keep a copy of this form for your records.

CONSENT FORM

I agree to participate in this study described above. I have made this decision based on the information I have read in the Information-Consent Letter. I have had the opportunity to receive any additional details I wanted about the study and understand that I may ask questions in the future. I understand that I may withdraw this consent at any time.

Name: _____

Signature: _____ Date: _____

APPENDIX H: Demographic Background and Cultural Sensitivity Survey

Please answer to the following questions to the best of your ability by writing X on the line where applicable. You may skip any questions that you do not wish to answer, and withdraw from the study at any time. Thank you for your time and participation.

1) **Please specify your gender:**

__ Male __ Female, __ Other

2) **What is your age range?**

___20-30 __ 30- 40 __ 40-50 __ 50-60 __ 60 and above

3) **Among the following categories, what is your highest level of education?**

___ Primary ___ Secondary ___ College/ university ____ Other ( )

4) **Please indicate your employment status at this home:**

___ Full-time ___ Part-time ___ Casual ____ Casual part-time

5) **How many years have you been working at this home?**

6) **Have you received any training that was related to cultural competence while working at this home?**

____ Yes (Please describe:) ____ No

7) **You were:**

___ Born in Canada

___ Immigrated to Canada ( ) years ago from ( )

___ other (Please specify)

8) How do you best describe your cultural background?

9) What language(s) do you speak at home? (You may select however many that apply)

___ English ___ French ___ other(s) (Please specify)

APPENDIX I: Focus Group Guide

- *Note: This is a tentative focus group interview guide. The researcher intends to modify/add questions based on the results of the key informant interview which will be conducted prior to the focus group.*

1) Introduction of the researcher & purpose of the study

2) Review the contents of informed consent form

3) Ask participants fill in the demographic form

4) Explanation of the ground rules (e.g., non-judgmental safe environment, respect each other's opinion, everybody speaks, keep confidentiality, etc.)

I. Work Conditions and the Environment of the LTC Home

1) Could you tell me about your work role at this home. Give me a general idea of a day in the life of a PSW at working here.

Probe: How do you see your work here? Are you very busy? Are you enjoying your work?

2) How long is your shift? What are the shift timings here? How often do you take a night shift?

3) Approximately how many residents do you interact with on a daily basis?
   a. Probe 1: Do you usually take care of the same people?
   b. Probe 2: Approximately how many minutes do you spend with 1 resident?
   c. Probe 3: How much interaction do you have with the residents here?
   d. Probe 4: Do you feel that you have the chance to get to know them?

4)What would you say is the cultural composition of the staff and residents at this home?

Probe 1: What is the ethno-cultural, religious, and language diversity among the residents?

Probe 2: How about the staff? Are you all from similar cultural backgrounds?

II. Everyday Practices, Experiences and Perception of Cultural Competence

5) How would you define "culture"?
   Probe: What kind of culture do you see in the LTC home?

6) How do your work conditions and training opportunities encourage or discourage you to practice culturally sensitive care?

7) Could you please describe what in-services, if any, are provided at this home? Are there any in-services provided at LTC home related to cultural sensitivity? If so, what are they like?

8) What do you feel would be needed to gain the most benefit from an in-service based on cultural sensitivity?

9) Have you experienced or encountered any challenges related to cultural differences in your work environment? If so, could you provide me with a few examples? How did you solve the problem?

   Probe 1: How do you find a balance in maintaining your professional duties and fulfilling the residents' personal cultural needs and preferences?
   Probe 2: How do you create a culturally sensitive/appropriate environment for the residents in this home?
   Probe 3: How much decision making power do you have under your work conditions?

10) Do residents ever express the need to continue his or her cultural practices?
   Probe 1: If so, how would the PSW staff accommodate?
   Probe 2: Under what circumstances a resident would be denied these wishes?

11) How would you define cultural competence or culturally sensitive care?
   Probe: Have you ever heard the word "cultural competence" in your training at college?

12) How do you think your own cultural background influences your professional role at this LTC home?

Probe 1: How much exposure have you had to diverse populations? How does your ethno-cultural and religious background and exposure to diverse populations influence your own cultural competent practice?
Probe 2: Do you think your professional training influences your cultural sensitivity? If so, how? If not, why?
Probe 3: Do you feel that your cultural background and your professional background become separate entities in decision making?

III.Future Prospects: Promoting Cultural Competence and Training Expectations

13) What do you think would be helpful in increasing your culturally sensitive care for the residents in this home? What changes would you like to see in the organization in order to create a culturally sensitive environment? (For example, in terms of organizational policies, work conditions, educational opportunities like in-service or cultural events, etc.)

12)In order to become a culturally sensitive PSW at this home, what would you like to learn?

Probe 1: What would be the best way to learn about cultural competence?
Probe 2: What changes would you like to see in the organization in order to create a culturally competent environment?

13) What do you think are the barriers to enhancing your own cultural sensitivity and create a culturally sensitive environment in this long term care home?

14) What future challenges do you foresee in relation to caring for ethnically and culturally diverse residents in this region?

Are there any closing remarks you would like to make?
Thank you for your time and participation. I will be in touch with you soon to discuss the themes from this study.

APPENDIX J: Focus Group Plan

Anticipated Problem	Potential Solution
Unexpected participant absences	Follow up letter and phone calls were made after participants had been recruited in order to confirm the date, time and location of the focus group.
Some participants speak more than others	1) Researcher will thank the participant for her contributions to the discussion and kindly ask the remaining participants to provide their insights. 2) Researcher will turn to the other participants in the room and ask their opinion on the content of the discussion.
Some participants speak less than others	1) At the beginning of, as well as during each focus group, the researcher will emphasize importance of equal contributions to the discussion 2) Researcher will call on a participant who is not speaking as often to ask his or her thoughts on the subject matter being discussed.
Participants provide one word answers or short statements such as "I agree" or simply nod their head to the other participants' responses.	Researcher will probe the participants with questions or statements such as "Would you explain further?" "Tell us more" "Please describe what you mean" or "Can you give us an example?"
Participants do not immediately respond to a question	Researcher will pause for at least 5 seconds after asking a question, before clarifying or rephrasing the question.
Participants provide responses that are related to a previous or preceding question	Based on the timing and the depth of discussion, the researcher will decide whether to use the probes that were prepared for that question or to follow the sequence of the focus group guide.

APPENDIX K : Letter of Approval from LTC Home

April 14, 2010

Ms. Aysha Tayab
Brock University
St. Catharines, Ontario L2S 3A1

Dear Aysha,

The Professional Advisory Committee at has reviewed your application for approval of your Research Project entitled "Cultural Competence and Its Role in Promoting Positive Change in the Delivery of Long Term Care: A Case Study," and under the supervision of Miya Narushima. Your request to use the as a participant in terms of policy document analysis, key informant interview, and focus groups has been approved. We will require a copy of your ethics approval from Brock University.

Please let me know if there is anything else you require. Best of luck with your project.

Sincerely,

Quality of Life Director
Chair, Professional Advisory Committee